

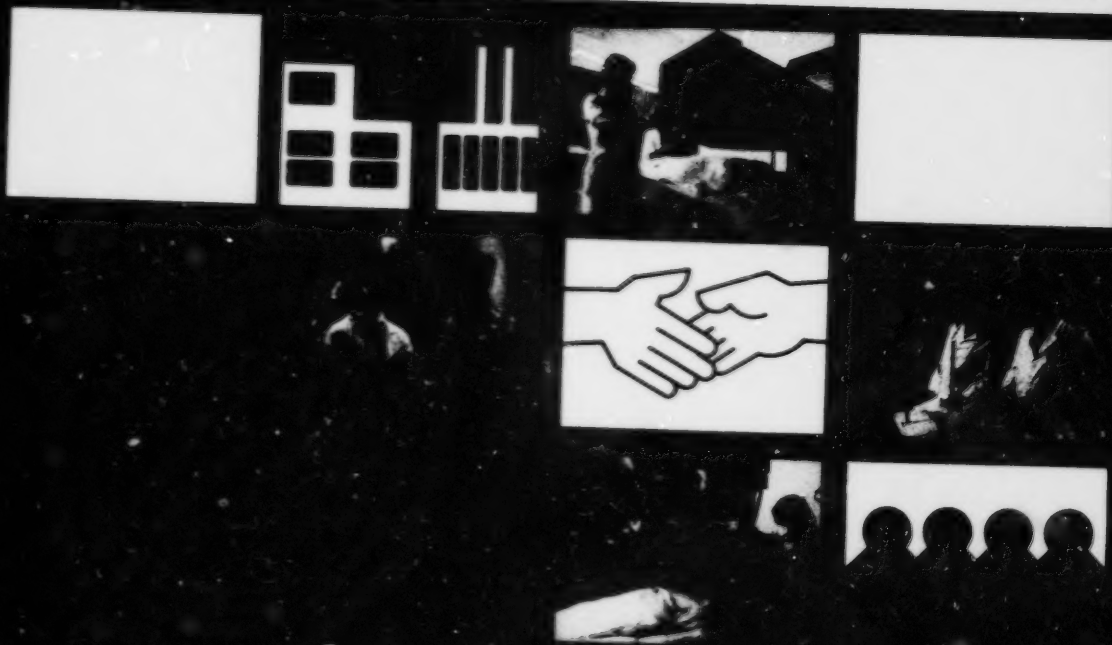


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Canadian Hospital Survey Report



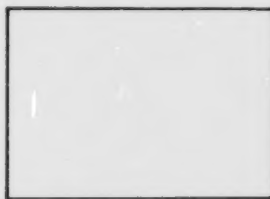
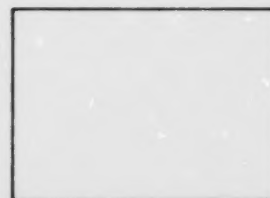
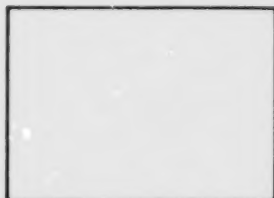
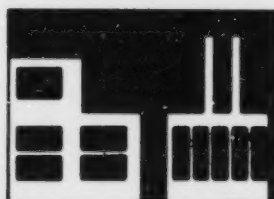
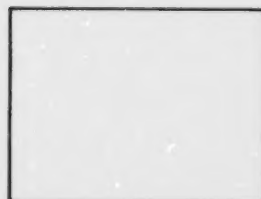
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THE WORKING ENVIRONMENT IN CANADIAN HOSPITALS CONSTRAINTS AND OPPORTUNITIES

by Joan Kahn and William A. Westley

quality of working life

Canadian Hospital Survey Report



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TABLE OF CONTENTS

	<u>Page</u>
PREFACE	ix
INTRODUCTION	
A. Characteristics of the Sample	xiii
B. Design of the Survey	xiv
PART ONE: PROBLEMS AND CONCERNS	
1. PURPOSE OF PART ONE OF THE NATIONAL HOSPITAL SURVEY	3
2. SOME METHODOLOGICAL CONSIDERATIONS	3
3. EMPLOYEE ATTITUDES AND BEHAVIOUR	3
3.1 Commitment to Organizational Goals	4
3.2 The Hospital as an "Open Sociotechnical System"	4
3.3 The Questionnaire and Study	6
3.3.1 Indicators of Employee Behaviour	6
3.3.2 Job Needs and Complaints	16
3.3.3 Special Indicators of the Quality of Working Life	25
4. CONCLUSIONS	32
PART TWO: INNOVATIONS AND SOLUTIONS	
FOREWORD	37
SECTION ONE: INNOVATIONS CLASSIFIED ACCORDING TO THE NATURE OF THE ENVIRONMENTAL INFLUENCES THAT PROVOKE THEM	39
1. GOVERNMENT REGULATIONS THAT IMPOSE SIGNIFICANT RESTRICTIONS ON HOSPITAL OPERATING BUDGETS	41
1.1 Cost Containment Committees, Departments, Programs, and Roles (General)	41
1.2 Cost Containment Committees or Programs (Specific)	41
1.3 The Creation of Special Extended Care Departments in Acute Care Facilities	42
1.4 Patient Classification Schemes	42
1.5 Day Care Units	42
1.6 Specific Cost Reduction Measures	42
1.7 Job Sharing	43

TABLE OF CONTENTS (Cont'd)

	<u>Page</u>
2. THE "TECHNOLOGICAL IMPERATIVE" TO PROVIDE "STATE OF THE ART" PATIENT CARE	43
2.1 Innovations Involving Biomedical Technology	43
2.1.1 New Organizational Structures	43
2.1.2 Recent Purchases of Biomedical Technology	44
2.2 Innovations Involving Non-Medical Technology	45
2.2.1 Computer Technology	45
2.2.2 Telecommunications, Paging Systems, etc.	46
2.3 In-Service Staff Education	46
2.3.1 General	46
2.3.2 Specialized	47
3. INNOVATIONS THAT ARE RESPONSES TO VARIOUS KINDS OF COMMUNITY DEMAND	47
3.1 Community Demand for Services that are Quality Assured with Respect to Specific Technologies and Skills	47
3.1.1 General Quality Assurance Innovations	47
3.1.2 Specific Quality Assurance Innovations	48
3.2 Community Demand for Services that are Integrated at the Level of Patient Care	49
3.2.1 Committees, Teams, Roles, Other	49
3.3 Community Demand for Services Organized Around Specific Problems and Needs	50
3.3.1 Innovations Organized Around Specific Problems	50
3.3.2 Innovations Organized Around Specific Needs	53
 SECTION TWO: INNOVATIONS CLASSIFIED ACCORDING TO THE NATURE OF THE ORGANIZATION'S RESPONSE TO ENVIRONMENTAL INFLUENCES	 57
1. BOUNDARY MAINTENANCE INNOVATIONS	59
1.1 Innovations Pertaining to Admissions and Discharges	59
1.2 Advisory Activities Directed at the Hospital's Need to Adapt to Environmental Changes	60
1.3 Innovations Involving Public Relations	61

TABLE OF CONTENTS (Cont'd)

	<u>Page</u>
2. INTRA-ORGANIZATIONAL INNOVATIONS	61
2.1 Innovations Having System-Wide Implications	61
2.1.1 Change in Hospital Goal	61
2.1.2 Change in Organization Chart	61
2.1.3 Change in Committee Structure	62
2.1.4 Change in Information System	62
2.2 Amalgamation (Centralization) of Authority and/or Services	62
2.2.1 Medical and Paramedical Functions	63
2.2.2 Non-Medical Functions	66
2.3 Decentralization of Authority and/or Services	67
2.3.1 Medical and Paramedical Functions	67
2.3.2 Non-Medical Functions	69
2.4 Creation of New Roles	69
2.4.1 Nursing Roles	70
2.4.2 Other Roles	70
2.5 Changes in Scheduling	72
2.6 Vertical Integration vs. Contracting Out	73
2.6.1 Vertical Integration	73
2.6.2 Contracting Out	73
2.7 Phasing Out	74
2.7.1 Phased Out Functions	74
2.7.2 Phased Out Clinics, Departments, Programs, Services, etc.	74
2.7.3 Phased Out Roles	74
3. INTER-ORGANIZATIONAL INNOVATIONS	75
3.1 Medical Support Services	75
3.2 Non-Medical Support Services	77
3.3 Mixed	77
 SECTION THREE: THE NECESSARY CONNECTION BETWEEN EMPLOYEE SATISFACTION AND THE PROVISION OF QUALITY HOSPITAL SERVICE	 79
1. MANAGEMENT INCENTIVE PROGRAMS	81
2. EMPLOYEE INCENTIVE PROGRAMS	81
3. EMPLOYEE ASSISTANCE PROGRAMS	82
4. SAFETY PROGRAMS	82
5. PLANNED SOCIAL EVENTS, CEREMONIES, ETC.	82

TABLE OF CONTENTS (Cont'd)

	<u>Page</u>
6. THE CREATION OF A SPECIAL ROLE	82
7. CHANGES IN SCHEDULING	83
SECTION FOUR: INNOVATIONS THAT REFLECT QUALITY OF WORKING LIFE VALUES	85
1. UNION-MANAGEMENT COLLABORATION	87
2. ROLE ENRICHMENT, CROSS-TRAINING, AND MULTI- SKILLING	88
2.1 Role Enrichment	88
2.2 Cross-Training and Multi-Skilling	89
3. MULTIDISCIPLINARY AND MULTI-LEVEL ACTIVITIES	91
APPENDICES	95
BIBLIOGRAPHY	111

PREFACE

Across the country, hundreds of Canadians, directly or indirectly, have contributed to the 1983 National Hospital Survey, and to the present report, which documents the results of that survey.

In Ottawa in 1982, Labour Canada launched an innovative program whose objectives were to improve the quality of working life in Canadian hospitals. "Quality of working life" is an approach to organizational improvement that emphasizes: (1) union-management collaboration, (2) employee participation in decision making, and (3) the treatment of the employee as a valuable human resource whose development within the organization--personal, occupational, and professional--helps to guarantee organizational effectiveness and growth.

Three main strategies were planned:

1. to hold regional quality of working life workshops in major cities across the country;
2. to conduct "mini-scans" of selected individual hospitals; and
3. to construct a national hospital survey, in order to identify the problems and concerns of Canadian hospitals and bring to light the various innovations and solutions which hospitals have implemented in response to these problems and concerns.

In order to facilitate this ambitious program, Labour Canada sought assistance from the Quality of Working Life Unit of McGill University in Montreal, in particular from the Director of the Unit, Dr. William Westley, and his associate, Dr. Joan Kahn, Project Director of the units Health Care Program.

Westley and Kahn subsequently conducted a series of six regional workshops in major cities across Canada--in Halifax, Winnipeg, Saskatoon, Edmonton, Calgary and Vancouver. At each location, they heard participants (hospital administrators, directors of nursing, personnel officers, union representatives, and representatives of the various provincial health associations) express their concerns and hopes about issues related to the quality of working life in their hospitals. Working in small groups representing both labour and management, participants were encouraged to cooperate to identify problems and design possible solutions to them. Participants not only worked through many of their own problems, but also contributed greatly towards a deeper and broader understanding of what Canadian hospitals were experiencing.

Then, in the autumn of 1982, Westley and Kahn conducted a three-day "mini-scan" of a large urban hospital located in the Maritimes. Following a series of intensive, one-hour interviews with approximately 25 people from all levels of that organization (professionals as well as non-professionals; union members as well as management), several main themes emerged from the accumulated interview data. These themes, which reflected the major concerns and aspirations of that institution, were then fed back during a one-day, on-site workshop, following which a recommendation was made by the hosts to further

explore the potential of quality of working life for their hospital by consulting with some local resource persons familiar with this approach to organizational redesign. The opportunity to conduct such an intensive analysis of the organizational patterns and problems of an individual hospital further added to the researchers' growing fund of knowledge in this area.

Another source of information was a series of sociotechnical analyses of hospital wards and departments in the Montreal area, conducted during 1981 and 1982 by teams of McGill undergraduate students (four per team, 58 teams in all) under the supervision of Dr. Westley and Dr. Kahn. These students attempted to look both at the social side of work (i.e. the network of roles and responsibilities and the indicators of job satisfaction) and the technical side of work (i.e. the equipment, skills, time and space required to carry out the step-by-step "unit operations" of each department, whether it be an operating room, a laundry or an outpatient department). As a further requirement of their field work assignment, students asked hospital workers and department heads the following question: "How do you know when you are doing a good job?" In this way, they attempted to identify the specific "output measures" that each department used (either implicitly or explicitly), to evaluate its own performance. At the conclusion of their analyses, the students proposed "redesigns", i.e. recommendations for change, which were based upon a set of sociotechnical principles developed by Albert Cherns and other writers in the field. Although it must be emphasized that the students were far from being professional hospital consultants, the freshness of their perceptions (not to mention their enthusiasm and industriousness) led them to make a number of thoughtful and sound recommendations for change. The set of 58 reports generated by these field work experiences (copies of which were sent to all participating hospital departments) constituted another valuable body of data pertaining to current hospital concerns.

For the present survey--the third strategy of Labour Canada's hospital program--scores of individuals from all levels of hospital organization (administrative, medical, nursing, paramedical, support staff, clerical workers, union representatives, etc.) were interviewed. Each interview invariably generated additional revisions, as did each pre-test of individual questionnaires (carried out both in Montreal and in some of the cities in which quality of working life workshops had been held). The final product, a five-part survey made up of a total of 194 questions, was next pre-coded, translated into French for Quebec participants, and sent out across the country in April, 1983.

The high rate of response from hospitals across Canada, and the fact that many hospital administrators took the time to prepare additional typewritten pages describing their concerns and innovations, clearly indicate that the survey achieved its goal of drawing together hospitals from all provinces for the common purpose of identifying problems and sharing solutions.

Certain individuals deserve special acknowledgment and thanks for having made a significant contribution to the survey and to the survey report. Audrey E. Bean and Carolyn Ordowich, Associate Directors of the Quality of Working Life Unit at McGill, provided astute and thoughtful advice throughout the project; Professor Roger Gosselin, Director of the Department of Health

Administration of the Faculty of Medicine of the University of Montreal, offered expert criticism and commentary; and Dr. Charles Cappell, Professor of Sociology at McGill, assisted in the design of the questions. Three research assistants--Henry Rono, Anne-Rose Goldin, and Bernice Wolanski--made up a dedicated and highly motivated team whose various tasks included data processing, programming, and analysis. Finally, Gerard Neray of the Department of Translation at McGill and Maryse Beaulieu worked on the translation, while Marianna Horvath prepared the final manuscript of the report on the word processor.



INTRODUCTION

In April 1983, questionnaires were sent to 392 hospitals across Canada. The population included all hospitals listed in the 1982 Canadian Hospital Directory with a reported bed capacity of 150 or more. Responses were obtained from 57% of the population, yielding a sample of 216 hospitals.

A. Characteristics of the Sample

a. Accreditation Status

. Accredited:	176 (81.5%)
. Non-accredited:	40 (18.5%)
Total	216 (100%)

b. Teaching Status

. Teaching Hospitals:	62 (28.7%)
. Non-teaching Hospitals:	154 (71.3%)
Total	216 (100%)

c. Type of Care

. General:	154 (71.3%)
. Long-term:	25 (11.6%)
. Mental Retardation Facility*:	13 (6.0%)
. Psychiatric:	24 (11.1%)
Total	216 (100%)

d. Statute

. Public:	211 (97.7%)
. Private:	4 (1.9%)
. Other:	1 (0.4%)
Total	216 (100%)

* The Canadian Hospital Directory does not include a listing of these institutions for the province of Quebec. All such institutions which participated in the survey, therefore, were located in the other nine provinces.

e. Population of City or Town in Which Hospital is Located

. Less than 10,000:	22 (10.2%)
. Between 10,000 and 49,000:	69 (32.0%)
. Between 50,000 and 99,999:	34 (15.7%)
. Between 100,000 and 499,999:	42 (19.4%)
. 500,000 or more:	49 (22.7%)

Total	216 (100%)
-------	------------

f. Distribution According to Province

British Columbia	20 (9.3%)
Alberta	16 (7.4%)
Saskatchewan	13 (6.0%)
Manitoba	10 (4.6%)
Ontario	69 (31.9%)
Quebec	62 (28.7%)
New Brunswick	7 (3.2%)
Nova Scotia	10 (4.6%)
Prince Edward Island	3 (1.4%)
Newfoundland	6 (2.8%)

Total	216 (100%)
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g. Distribution According to Bed Size

Category:

. 150-246 beds	65 (30.1%)
. 247-383 beds	65 (30.1%)
. 383-2,500 beds	86 (39.8%)

Total	216 (100%)
-------	------------

B. Design of the Survey

The survey was designed in two parts. Part One was intended to help identify the major organizational problems of Canadian hospitals, and to correlate these problems with some of the hospital characteristics indicated above. Organizational problems were understood to include two distinct yet related types: (a) those concerning the attitudes and behaviour of hospital employees, and (b) those concerning hospital performance (in general) and quality of patient care (in particular).

Part One consisted of four different questionnaires. These were mailed individually to persons occupying different roles within the same hospital, on the assumption that each of these individuals would very likely possess knowledge of different aspects of the organization. Thus, Part One (A) was sent to the director of nursing (or equivalent), Part One (B) was sent to the personnel director (or equivalent), Part One (C) was sent to the executive director (or his/her designated assistant, e.g., the director of hospital services).

Part One (D), intended for union representatives, was sent to the director of personnel, along with a covering letter requesting that enough copies be made to permit distribution to all union representatives in that hospital.

Each questionnaire from Part One generated a separate sub-sample: Part One (A) produced a sub-sample of 93; Part One (B): 93; Part One (C): 92; and Part One (D): 158. The data obtained from all four sub-samples were processed by computer, with the exception of responses to two "open-ended" questions, which were processed manually.

To assure anonymity for Part One of the survey, each hospital was randomly assigned its own number. The inscription of this number on each of the four questionnaires made it possible to integrate these four sources of data for statistical purposes. A report based on Part One*, in which the results appear only in statistical form, was promised to each participating hospital.

Part Two of the survey, by contrast, consisted of only one questionnaire, which was sent to the executive director (or to his/her designated assistant). This part of the survey (which was processed manually) generated a sub-sample of 97. The objective in this case was to identify recent innovations and solutions which Canadian hospitals have implemented in response to some of their organizational problems, with a view to an eventual sharing of these solutions through the medium of a subsequent report** (again, to be sent to all participating hospitals). Recipients of Part Two, therefore, were asked to identify the names of their respective hospitals in order that other hospitals would be able to obtain follow-up information on successful and tested innovations about which they would like to learn more. To facilitate this information-sharing process, each innovation appearing in the report was identified with a code number referring the reader to the name, address, and telephone number of the particular hospital by which the innovation was reported.

Two underlying assumptions have helped to shape the design of the survey:

- a. that hospitals are systems of roles and functions, and as such, are best understood if one consults people working at various levels of the organization; thus the design feature of constructing five separate role-specific questionnaires; and
- b. that issues pertaining to the quality of working life of hospital employees are likely to have repercussions upon hospital performance in general, as well as upon the quality of patient care in particular; thus the design feature of including questions that pertain both to employee behaviour and attitudes and to hospital performance.

* Entitled 1983 Canadian Hospital Survey Report, Part One: Problems and Concerns.

** Entitled 1983 Canadian Hospital Survey Report, Part Two: Innovations and Solutions.



1983

PART ONE: PROBLEMS AND CONCERNS

by

William A. Westley



1. PURPOSE OF PART ONE OF THE NATIONAL HOSPITAL SURVEY

The purpose of Part One of the survey was to identify organizational problems of Canadian hospitals. Questions concerning organizational problems fell largely into two groups: (a) those which inquired about employee attitudes and behaviour (both of which are related to the issue of employee motivation), and (b) those which inquired about various aspects of hospital performance in general and the quality of patient care in particular. Questions pertaining to (a) were asked primarily of directors of nursing, personnel directors, and union representatives. Questions pertaining to (b) were asked primarily of directors of nursing and executive directors.

2. SOME METHODOLOGICAL CONSIDERATIONS

The data were analyzed through McGill Computing System, with SPSSX (i.e., the latest version of the Statistical Package for the Social Sciences). Both frequencies and cross-tabulations were obtained from sub-programs of SPSSX.

The total data set consisted of four subsets (A, B, C and D) from Part One of the survey. Another six variables were added to the data set from the 1982 Canadian Hospital Directory. These additional variables encompassed the following demographic data: (1) accreditation status, (2) type of care provided, (3) ownership status, (4) type of statute (i.e., public, private, etc.), (5) rated bed capacity, and (6) teaching status. An additional variable, namely (7) the population of the city or town in which the responding hospital was located, was obtained from the 1982 Canadian Almanac. The seven variables indicated above were added to the survey data for two reasons: (1) the Canadian Hospital Directory and the Canadian Almanac are accepted sources of reliable data about these variables, and (2) data for these variables were not always readily available from each part of the survey.

For purposes of cross-tabulation, interval variables such as population of the city and rated bed capacity were recoded into ordinal variables.

The technical terms that appears on the tables are described in Appendix 3.

3. EMPLOYEE ATTITUDES AND BEHAVIOUR

This section deals with survey results reflecting the motivational behaviour of employees in Canadian hospitals, that is: (1) the degree to which employees are committed to organizational goals, and (2) the degree to which employees experience job satisfaction in their work.

Design of Tables 1 to 30

In order to avoid misinterpretation of the data, Tables 1 to 30 should be read with the understanding that Column A reflects reports made by directors of nursing about the motivational behaviour of employee group A over the past

three years. Employee group A consists of two sub-groups: professional nurses (e.g., Registered Nurses, Registered Psychiatric Nurses, etc.), and non-professional nursing staff (e.g., Licensed Practical Nurses, orderlies, etc.). Similarly, Column B reflects reports made by personnel directors about the motivational behaviour of employee group B over the past three years. Employee group B is made up of two sub-groups: medical support staff, such as laboratory technicians, physiotherapists, radiological technicians, etc., and non-medical support staff, such as maintenance, laundry, and kitchen staff.

In some instances, a comparison will be drawn between data pertaining to professional hospital workers (as represented by professional nurses and medical support staff in the tables), and non-professional hospital workers (as represented by non-professional nursing staff and non-medical support staff in the tables).

For certain tables, a third column will appear, Column C. Column C reflects reports made by union representatives about the attitudes and behaviour of all unionized employee groups (both professional and non-professional), which they represent in their respective hospitals. The existence of this category, however, is not meant to imply anything about the extent or absence of unionization within employee groups A and B.

3.1 Commitment to Organizational Goals

In the majority of cases, employees will commit themselves to the goals of an organization only if those goals reflect certain social values which employees find worthwhile and can respect. When such employees have the opportunity to participate in the achievement of these goals, they come to experience increased feelings of self-respect, self-enhancement, and self-worth. Such feelings constitute powerful psychological and social rewards, and encourage continued participation.

An employee who is committed to the goals of the hospital (or, for that matter, any organization) tends to display certain characteristic attitudes and behaviours such as (a) adhering to recommended work standards, (b) helping co-workers and supervisors, (c) following directives of co-workers and supervisors when required, (d) assuming responsibility for carrying out agreed-upon tasks, (e) performing duties, when required, that are not necessarily part of their job descriptions, and (f) working overtime on occasion when the situation requires it. Employees who behave this way do so not because they are compelled to, nor because they are overly compliant. They do so only because such behaviour "makes sense" to them in terms of (a) how their own daily tasks relate to those of their supervisors and co-workers, and (b) how all tasks relate to the goals of the hospital.

3.2 The Hospital as an "Open Sociotechnical System"

A quality of working life (QWL) orientation to hospitals implies that hospitals are "open sociotechnical systems". They are:

- a. systems, because they are wholes made up of interdependent subsystems and parts;

- b. sociotechnical, because they include (1) a social subsystem (i.e., the network of organizational roles and relationships), and (2) a technical subsystem (the technological equipment and skills required to perform the work);
- c. open systems, because they interact dynamically with their environment, affecting and in turn being affected by it.

The QWL approach also assumes that for organizational stability to be maintained, power must be distributed and work divided in a way that (a) makes the organization compatible with the environment, and (b) jointly optimizes the performance of the social and technical subsystems. Thus as each new external influence affects the hospital, a corresponding internal change is generally required in order to maintain organizational goals.

Three of the major influences currently affecting hospitals are the rapid proliferation of biomedical technology, changes in the socioeconomic needs and career expectations of hospital employees, and government regulations, particularly those which impose severe constraints on operating budgets.

Under these external influences, hospitals begin to show symptoms of stress: employee dissatisfaction expressed in alienation and withdrawal of services, internal conflicts and confusion, and lowered levels of productivity, quality and efficiency.

These stresses create a demand for change. Many organizations throughout the western and industrial world are re-evaluating their workplaces and moving towards new ways of defining work and power within the organization. The quality of working life movement represents a major current in this river of change. Organizations as diverse as offices, factories, government bureaus, schools, and hospitals are finding in this approach a better way to analyze the "fit" between the form of the organization, the needs and demands of the people and of the technology, and the responsiveness of the organization to the environment; and many are creating new forms of organization, usually designed along "open sociotechnical systems" lines, in order to improve that fit.

Perhaps more than any other type of organization, hospitals have grown in size and complexity over the years. Highly labour-intensive (over 70% of normal hospital budgets are generally devoted to wages), they are daily confronted with demands made by young and highly educated employees. Also, due to a general growth of medical insurance and government support for medical care, public demands on hospital services have risen with incredible speed, along with a corresponding awakening of citizens' awareness of their rights. The hospital, always a very traditional organization, desperately needs to find new forms to adapt to these drastic changes. Indeed, hospitals have been struggling to do just that, either by adding to their staffs new kinds of specialists trained in personnel relations, quality assurance, risk management, etc., or else by designing new kinds of programs, virtually unheard-of 25 years ago, for both patients and employees.

3.3 The Questionnaire and Study

In an effort to find out to what degree Canadian hospitals are experiencing these changes and stresses, the McGill Quality of Working Life Unit, in conjunction with Labour Canada, made a survey of Canadian hospitals to probe the quality of working life found within them. Each hospital received questionnaires for four different categories of personnel. However, key questions were repeated in two or more of the different questionnaires.

The questions were divided into two broad groups: those that inquired about employee attitude and behaviour, and those that inquired about symptoms of organizational malfunction and absence of integrated purpose. With respect to the second group of questions, and despite assurances of confidentiality, most respondents apparently felt sensitive about providing information which might harm the reputation of their hospitals, for they clearly seemed reluctant to report increases in: diagnostic errors, lost medical records, lost x-ray film, diet-related errors, poor communications, deaths, allergic reactions, surgical complications, post-surgical complications (e.g., infections, pneumonia, phlebitis) and, finally, hospital suicides. In general, respondents tended to report either no change in these areas, or else an improvement. We assume that for many this represented caution, since these results do not accord with our pre-tests and case studies.

While we would hope that the generally conservative responses to the more sensitive questions are accurate, we have some nagging doubts. In other types of work organization, symptoms of employee distress are linked to various kinds of organizational malfunction, such as poor quality, excessive costs, excessive waste, and interdepartmental conflict and confusion. We see no reason that this would not also be true of hospitals.

On the other hand, we do appreciate respondents' openness in reporting employee attitudes and behaviour. The reports indicate that hospitals have many quality of working life problems, which were reported most commonly among non-professional employees, in particular, the non-medical support staff (e.g., maintenance, housekeeping, laundry workers).

Thus our report tends to focus on responses to questions that probe employee attitudes and behaviour rather than on responses to questions concerning hospital functioning (since most reports on the latter group indicated "no change").

3.3.1 Indicators of Employee Behaviour

Six questions asked of the directors of nursing and directors of personnel focussed on their perceptions of possible changes in employee behaviour (although the term used was "Attitudes") over the past three years.

These questions were asked with respect to four groups of employees:

- a. Professional nurses or professional nursing staff (Registered Nurses, graduate nurses, etc.);

- b. Non-professional nursing staff (Certified Nursing Assistants, nursing aids, orderlies, etc.);
- c. Medical support staff (staff working in radiology, laboratories, physiotherapy, etc.);
- d. Non-medical support staff (staff working in maintenance, laundry, housekeeping, etc.).

In general, the responses of the directors of nursing and directors of personnel indicated that, among the first three employee groups, there was little or no change over the past three years, with some exceptions (such as major improvement in adherence to nursing standards by nurses).

Presumably, the first three groups--that is, the professional nurses, the non-professional nursing staff, and the medical support staff--are backed up by professional codes and ethics which give them a strong commitment to their jobs. However, among the non-medical support staff this is not the case, and here the directors of personnel reported substantial decreases in commitment to the hospital and its goals with respect to the following: adherence to work standards, willingness to help co-workers and supervisors, willingness to assume responsibility for carrying out tasks, willingness to follow directives of co-workers and supervisors, willingness to perform duties that are not specifically part of one's job description, and, finally, the willingness to work overtime. Thus we find that a higher percentage of directors of personnel perceived a decrease than perceived an increase in commitment to the hospital and its goals.

In teaching hospitals this pattern is accentuated, and there is a statistically significant difference between teaching and non-teaching hospitals with respect to the percentage reporting such decreases in commitment. It is probable that teaching hospitals are relatively more complex, larger and more bureaucratic than non-teaching hospitals. In other technocratic bureaucracies, modern workers are reacting with a similar pattern of alienation and withdrawal. Indicators such as a decreased willingness to work overtime or to perform duties not in the job description are especially valuable in judging the degree of alienation and withdrawal. Directors of personnel usually have hard data on these indicators, so we can assume that they represent more than just a personal judgement of the trend.

We will now review each of the six questions, presenting our findings from the survey.

(1) Adherence to Recommended Work Standards

Table 1 presents the percentage of directors of nursing and of personnel who reported that adherence to work standards has either decreased, remained unchanged, or increased over the past three years. Note that only with respect to the non-medical support staff does a larger percentage of directors report a decrease rather than an increase. Although not large, the difference between the various types of employees is marked.

Table 1

Adherence to Recommended Work Standards

Response Category	A Director of Nursing		B Personnel Director	
	Professional Nurses	Non-Professional Nursing Staff	Medical Support Staff	Non-Medical Support Staff
Decreased	13.0	13.3	7.7	20.4
Unchanged	23.9	47.8	63.7	63.4
Increased	63.0	38.9	28.6	16.1
	100%	100%	100%	100%
	(n=92)	(n=90)	(n=91)	(n=93)

(2) Willingness to help co-workers and supervisors

Table 2 indicates that most directors of nursing and of personnel reported no change in the level of willingness to help. We find a balance between the percentage of hospitals reporting increases in such willingness and the percentage of hospitals reporting decreases.

Table 2

Willingness to Help Co-Workers and Supervisors

Response Category	A Director of Nursing		B Personnel Director	
	Professional Nurses	Non-Professional Nursing Staff	Medical Support Staff	Non-Medical Support Staff
Decreased	25.8	21.1	14.4	21.5
Unchanged	48.4	60.0	65.6	61.3
Increased	25.8	18.9	20.0	17.2
	100%	100%	100%	100%
	(n=93)	(n=90)	(n=90)	(n=93)

However, when reports concerning this issue are compared between teaching and non-teaching hospitals, and with respect to the non-medical support staff, there is a substantial difference in the proportion of directors reporting a decrease in teaching hospitals (see Table 3 below).

Table 3
Willingness to Help Co-Workers and Supervisors
(Among Non-Medical Support Staff by Hospital Teaching Status)

Category Response	Teaching	Non-Teaching
Decreased	32.3	16.1
Unchanged	67.7	58.1
Increased	—	25.8
	100%	100%
	(n=31)	(n=62)
$\chi^2 = 10.82$	d.f. = 2	P = 0.01
		Cramer's V = 0.34

Note that in teaching hospitals, 32.3% of personnel directors reported a decreased willingness on the part of the non-medical support staff to help co-workers and supervisors, and that no personnel directors reported an increase in such willingness. Note also that the chi square is significant and the association is strong.

(3) Willingness to follow directives of co-workers and supervisors

Here again the proportion of directors of nursing who reported a decrease rather than an increase is roughly the same for all categories of personnel, except for the non-medical support staff. For that group, more than twice as many directors of personnel reported a decreased willingness (see Table 4).

Table 4

Willingness to Follow Directives of Co-Workers and Supervisors

Response Category	A Director of Nursing		B Personnel Director	
	Professional Nurses	Non-Professional Nursing Staff	Medical Support Staff	Non-Medical Support Staff
Decreased	20.4	14.4	14.4	24.7
Unchanged	57.0	68.9	74.4	64.5
Increased	22.6	16.7	11.1	10.8
	<u>100%</u>	<u>100%</u>	<u>100%</u>	<u>100%</u>
	(n=93)	(n=90)	(n=90)	(n=93)

Again, however, if we control for the teaching status of the hospital, there is an overwhelming increase in the proportion of directors of personnel who report that the non-medical support staff have a decreased willingness to follow directives. Note also that the chi square is significant and the association is strong (see Table 5 below).

Table 5

Willingness to Follow Directives of Co-Workers and Supervisors
(Among Non-Medical Support Staff by Hospital Teaching Status)

Response Category	Teaching	Non-Teaching
Decreased	41.9	16.1
Unchanged	58.1	67.7
Increased	--	16.1
	<u>100%</u>	<u>100%</u>
	(n=31)	(n=62)
$\chi^2 = 10.8$		d.f. = 2
P = 0.004		Cramer's V = 0.34

(4) Willingness to assume responsibility

Only with respect to the professional nurses do more directors say there was an increase rather than a decrease in willingness, but the results are relatively balanced between decrease and increase, suggesting that there has been little change. For non-medical support staff, however, more than three times as many directors of personnel indicated a decreased willingness as reported an increased willingness, suggesting a trend to resist involvement among this group (see Table 6 below).

Table 6
Willingness to Assume Responsibility

	A Director of Nursing		B Personnel Director	
Response Category	Professional Nurses	Non-Professional Nursing Staff	Medical Support Staff	Non-Medical Support Staff
Decreased	23.7	23.3	11.2	22.6
Unchanged	47.3	55.6	70.8	71.0
Increased	29.0	21.1	18.0	6.5
	<u>100%</u>	<u>100%</u>	<u>100%</u>	<u>100%</u>
	(n=93)	(n=90)	(n=89)	(n=93)

When we control for the teaching status of the hospital (see Table 7), we see that a much greater proportion of directors of personnel in teaching hospitals say that the non-medical support staff show a decreased willingness to assume responsibility.

Note again the high chi square, the significance and the strong association.

Table 7

**Willingness to Assume Responsibility
(Among Non-Medical Support Staff by Hospital Teaching Status)**

Response Category	Teaching	Non-Teaching
Decreased	35.5	16.1
Unchanged	64.5	74.2
Increased	—	9.7
	100%	100%
	(n=31)	(n=62)
$\chi^2 = 6.70$	d.f. = 2	P = 0.03
		Cramer's V = 0.27

(5) Willingness to perform duties that are not specifically part of one's job description

This question was intended to find out whether there has been a change in the way workers define their work obligations. Do they feel that they ought to do anything they are asked, and as much as possible, or do they feel that they should do only what is in their job description and what they have specifically contracted to do? The question is an important one in hospitals, where there is a high degree of uncertainty (e.g., in emergency situations), which may require workers to do jobs not in their job description but essential to help the patient.

Table 8 shows that, in a large proportion of hospitals, the directors of nursing and of personnel report that there is a decreased willingness on the part of all categories of personnel to perform duties not in their job description. We draw particular attention to 60.2% of the directors of nursing who report such a decrease in the willingness of nurses, and the 45.2% of the directors of personnel who report such a decrease in the willingness of non-medical support staff (see Table 8).

Table 8

**Willingness to Perform Duties Not Specifically
Part of One's Job Description**

Response Category	A Director of Nursing		B Personnel Director	
	Professional Nurses	Non-Professional Nursing Staff	Medical Support Staff	Non-Medical Support Staff
Decreased	60.2	44.4	33.3	45.2
Unchanged	32.3	45.6	55.6	46.2
Increased	7.5	10.0	11.1	8.6
	100%	100%	100%	100%
	(n=93)	(n=90)	(n=90)	(n=93)

Table 8 seems to reflect certain changes in the industrial climate of hospitals, as well as in the attitudes towards work in our society as a whole. Today, more workers are conscious of their union contracts and are adhering to them. More have developed adversarial relationships with the hospitals that employ them, and are therefore not willing to do anything they have not contracted for, nor been specially paid for.

Again, a much higher proportion, of directors of personnel in teaching hospitals report a decreased willingness on the part of non-medical support staff to perform duties not part of one's job description (see Table 9 below).

Table 9

**Willingness to Perform Duties Not Specifically
Part of One's Job Description
(Among Non-Medical Support Staff by Hospital Teaching Status)**

Response Category	Teaching	Non-Teaching
Decreased	64.5	35.5
Unchanged	32.3	53.2
Increased	3.2	11.3
	100%	100%
	(n=31)	(n=62)
$\chi^2 = 7.38$	d.f. = 2	P = 0.02
		Cramer's V = 0.28

Note that 64.5% of the directors of personnel, a substantial majority, report a decrease in the willingness to perform extra duties. Note also the high chi square significance and association.

(6) Willingness to work overtime

Today, there is abundant evidence that Canadian workers resent overtime, and prefer time for their private lives. One interpretation may be that as work satisfaction decreases, the recreational satisfaction of family and social life increases. Also, it is possible that as people's expectations rise, the work world seems increasingly unsatisfactory.

Table 10 indicates that in a large proportion of Canadian hospitals, directors of nursing and of personnel find there is a decreased willingness to work overtime. This supports the idea that workers increasingly are rejecting work in favour of their private lives.

Table 10
Willingness to Work Overtime

Response Category	A Director of Nursing		B Personnel Director	
	Professional Nurses	Non-Professional Nursing Staff	Medical Support Staff	Non-Medical Support Staff
Decreased	27.2	29.2	20.0	30.1
Unchanged	62.0	52.8	68.9	57.0
Increased	10.9	18.0	11.1	12.9
	100%	100%	100%	100%
	(n=92)	(n=89)	(n=90)	(n=93)

Again, when we control for the teaching status of the hospital, we find that a large proportion of the directors of personnel in teaching hospitals report a decreased willingness to work overtime on the part of non-medical support staff (see Table 11).

Table 11

Willingness to Work Overtime
(Among Non-Medical Support Staff by Hospital Teaching Status)

Response Category	Teaching	Non-Teaching
Decreased	48.4	21.0
Unchanged	41.9	64.5
Increased	9.7	14.5
	100%	100%
	(n=31)	(n=62)
$\chi^2 = 7.38$	d.f. = 2	P = 0.02
		Cramer's V = 0.28

Table 11 shows that, in teaching hospitals, 48.4% of directors of personnel reported a decrease in willingness as compared with 9.7% reporting an increase. Note also that the relationship between the proportion reporting decreased willingness and the status of the hospital is significant at the 0.02 level, and shows a strength of Cramer's V of 0.28.

Some observations on this section:

- a. In areas where there are no norms of professional behaviour (especially among non-medical support staff such as laundry workers), a decrease has been reported in the general willingness to work towards organizational goals. Among the other groups, professional ethics have presumably provided some resistance to changing attitudes in the population, and willingness has not decreased significantly (except in "job specs" such as working overtime or performing duties not specifically part of one's job description).
- b. Further, in those areas not subject to professional codes (such as working overtime and willingness to do extra duties), all categories of personnel, even the professional nurses, show a decreased willingness. This clearly reflects the changing industrial relations climate of hospitals, and the withdrawal of all categories of personnel from a commitment to hospital goals.
- c. Finally, the non-medical support staff show a much stronger negative reaction in teaching than in non-teaching hospitals. Such evidence of stress is not surprising, since teaching hospitals must be most responsive to change, to new developments in technology, and to

community demands. Figures for non-medical support staff indicate that these hospitals are experiencing serious problems in gaining the commitment of workers in the non-medical support areas. Yet these are exactly the hospitals which most need high standards and commitment from all of their people (non only the highly educated ones) if they are to serve their function of being pacesetters for the medical community. Thus we find a conjunction of decreased commitment, probably increased expenses, and undoubtedly increased strain.

3.3.2 Job Needs and Complaints

Another set of questions focussed on employees' complaints about their jobs, such as: the lack of opportunity to make decisions, the lack of opportunity to learn new skills, the lack of opportunity for advancement, the lack of mutual respect and support among co-workers, boredom with their jobs, and the lack of meaningfulness of their task. Improving such working conditions is the focus of many current redesign efforts in various types of organization. The respondents in this case--directors of nursing, directors of personnel and union officers--were asked whether various types of employees made such complaints often, sometimes or never.

The majority of all respondents report that all types of employees complain about the various job frustrations indicated above either sometimes or often. What is impressive about this finding is that (1) the revolution of rising job expectations is evidently well advanced in hospitals, and (2) most employees see it as legitimate to complain if the job does not meet such expectations. This is a change from the kinds of complaints which were considered legitimate in traditional work organizations, and which were often embodied in the labour contract--complaints about abuse of management privilege, salaries, hours, health and safety, and other conditions of work. Clearly, employees themselves have widened the definition of job satisfaction, and if they are to be satisfied with their jobs, their jobs will have to change.

A second general finding of note is that a majority of union officers reported that workers often complained about the lack of autonomy (53.5%), and the lack of advancement (50%). In addition, a large proportion (41.7%) reported that employees often complained about the lack of opportunity to learn new skills.

Third, the percentage of directors of nursing reporting that nurses complained about boredom sharply decreased (1) with a decrease in hospital size, and (2) for general and teaching hospitals as compared to other types of hospitals. Evidently nurses find their work more interesting in teaching and general hospitals and, other things being equal, in smaller rather than larger hospitals.

(7) Complaints about the lack of opportunity to make decisions

Most directors of nursing and directors of personnel evidently felt that while all categories of workers complained about the lack of opportunity to make decisions, they did not do it often. However, the point of view of the union officers is sharply different: 52.5% of the 185 union leaders reporting stated that workers often complained about the lack of opportunity to make decisions.

It is difficult to interpret this finding. Perhaps these workers made such complaints more frequently to the union leaders than to the directors, and/or the union leaders were more frank about reporting this.

Table 12

Complaints About the Lack of Opportunity to Make Decisions

Response Category	A Director of Nursing		B Personnel Director		C Union Officer
	Professional Nurses	Non- Professional Nursing Staff	Medical Support Staff	Non- Medical Support Staff	Group C
Often	14.3	19.8	8.7	12.9	53.5
Sometimes	61.5	63.7	64.1	68.8	37.8
Never	24.2	16.5	27.2	18.3	8.6
	<u>100%</u>	<u>100%</u>	<u>100%</u>	<u>100%</u>	<u>100%</u>
	(n=91)	(n=91)	(n=92)	(n=93)	(n=185)

With respect to professional nurses, as the size of the city increased, there was a sharp increase in the proportion of directors of nursing who reported frequent complaints about the lack of opportunity to make decisions. In other words, nurses from large urban areas seemed to be more likely to make demands for autonomy than nurses from small rural areas.

Table 13

**Complaints About the Lack of Opportunity to Make Decisions
(Among Nurses by Population of City in Which Hospital is Located)**

Response Category	POPULATION				
	10,000	10,000 to 49,999	50,000 to 99,999	100,000 to 499,999	500,000
Often	10.0	10.0	21.4	30.4	—
Sometimes	90.0	50.0	71.4	47.8	65.2
Never	—	40.0	7.1	21.7	34.8
	100%	100%	100%	100%	100%
	(n=10)	(n=20)	(n=14)	(n=23)	(n=23)
$\chi^2 = 18.23$ d.f. = 8 P = 0.02 Gamma = 0.14					

Note that 40% of the directors of nursing from small centres reported that nurses never complained about a lack of opportunity to make decisions, and only 10% said they complained often; however, 30% of the directors of nursing from large urban areas reported that they often complained, and only 21% that they never complained. The relationship is significant at the 0.02 level with a Gamma of 0.14.

(8) Complaints about the lack of opportunity to learn new skills

Learning has long been seen as an essential quality of life for most North Americans, who spend a great deal of time in various types of self-learning and formal learning situations. We know that workers regard this job attribute as one which makes their jobs more attractive.

Table 14 shows that all respondents said workers complained about the lack of learning opportunities, but only among the union representatives did a substantial proportion (41%) say that workers often made this complaint.

Table 14

Complaints About the Lack of Opportunity to Learn New Skills

	A Director of Nursing		B Personnel Director		C Union Officer
Response Category	Professional Nurses	Non- Professional Nursing Staff	Medical Support Staff	Non- Medical Support Staff	Group C
Often	5.5	14.3	5.5	7.5	41.7
Sometimes	71.4	62.6	59.3	69.9	47.4
Never	23.1	23.1	35.2	22.6	10.9
	<u>100%</u>	<u>100%</u>	<u>100%</u>	<u>100%</u>	<u>100%</u>
	(n=91)	(n=91)	(n=91)	(n=93)	(n=192)

(9) Complaints about the lack of opportunity for advancement

Following the pattern we have already noted, the respondents indicated that all categories of workers made such complaints. Again, only among union representatives did a substantial proportion (50%) report that workers often made these complaints (see Table 15).

Table 15

Complaints About the Lack of Opportunity for Advancement

Response Category	A Director of Nursing		B Personnel Director		C Union Officer
	Professional Nurses	Non- Professional Nursing Staff	Medical Support Staff	Non- Medical Support Staff	Group C
Often	15.4	24.4	10.9	9.7	50.0
Sometimes	67.0	56.7	62.0	72.0	39.4
Never	17.6	18.9	27.2	18.3	10.6
	100%	100%	100%	100%	100%
	(n=91)	(n=90)	(n=92)	(n=93)	(n=188)

(10) Complaints about the lack of mutual respect and support among co-workers

Except for the medical support staff, i.e., the paramedical specialties, the respondents overwhelmingly reported that all categories of workers made such complaints. But only among the union leaders did a substantial proportion report that workers often made this complaint (see Table 16).

Table 16

**Complaints About the Lack of Mutual Respect and Support
Among Co-Workers**

Response Category	A Director of Nursing		B Personnel Director		C Union Officer
	Professional Nurses	Non- Professional Nursing Staff	Medical Support Staff	Non- Medical Support Staff	Group C
Often	6.6	13.2	5.5	10.8	25.1
Sometimes	73.6	68.1	50.5	75.3	56.7
Never	19.8	18.7	44.0	14.0	18.1
	<u>100%</u>	<u>100%</u>	<u>100%</u>	<u>100%</u>	<u>100%</u>
	(n=91)	(n=91)	(n=91)	(n=93)	(n=187)

Although the majority of all respondents reported that hospital employees made this complaint, only a modest proportion (with the exception of union representatives) said that workers often made this complaint. We find this surprising since, in traditional organizations, workers place a high value on mutual respect and support and consider it to be an important attribute of a job. One possible interpretation is that most hospital workers find they do get mutual respect and support and, therefore, do not complain about it very much.

Among the non-medical support staff, the frequency of such complaints seems to rise with an increase in the size of the city in which the hospital was located. As the population increases, so does the proportion of directors of personnel reporting this as a frequent complaint.

Table 17

**Complaints About the Lack of Mutual Respect and Support Among Co-Workers
(Among Non-Medical Support Staff by Population of City)**

Response Category	POPULATION				
	10,000	10,000 to 49,999	50,000 to 99,999	100,000 to 499,999	500,000
Often	—	5.7	—	10.0	28.6
Sometimes	50.0	85.7	91.7	75.0	57.1
Never	50.0	8.6	8.3	15.0	14.3
	100%	100%	100%	100%	100%
	(n=4)	(n=35)	(n=12)	(n=20)	(n=21)
$\chi^2 = 15.84$ d.f. = 8 P = 0.04 Cramer's V = 0.28					

Since we have not established a correlation with either the teaching status of the hospital nor the size of the hospital, we find it very difficult to interpret this finding. One possibility, which could be probed further, is that workers coming from larger rather than smaller urban areas have a greater tendency to be calculative and independent in their jobs, and to refuse to demonstrate respect and support for their fellows. We have no grounds but speculation for saying this.

(11) Complaints about boredom with their jobs

Table 18 shows that respondents found that all classes of employee (except medical support staff) complain often or sometimes about boredom with their jobs. One interesting and unexpected finding was that the proportion of directors of nursing reporting that nurses complained about boredom increased as the size of the hospital increased, and as one moved from non-teaching to teaching hospitals.

This probably reflects the expectations people bring to their work more than the character of the work itself. Other studies have revealed that older workers, who generally complain less about their work, tend to do so because they expect less of it. These complaints about boredom, therefore, may reflect the rising expectations workers bring to their jobs and indicate that such workers will be dissatisfied unless their jobs can be changed to provide additional variety and challenge.

Table 18
Complaints About Boredom With Their Jobs

	A Director of Nursing		B Personnel Director		C Union Officer
Response Category	Professional Nurses	Non-Professional Nursing Staff	Medical Support Staff	Non-Medical Support Staff	Group C
Often	4.4	17.4	1.1	10.8	21.2
Sometimes	59.3	58.7	52.2	73.1	58.5
Never	36.3	23.9	46.7	16.1	20.2
	<u>100%</u>	<u>100%</u>	<u>100%</u>	<u>100%</u>	<u>100%</u>
	(n=91)	(n=91)	(n=92)	(n=93)	(n=188)

Table 19 shows that, with an increase in hospital size, an increase was found in the percentage of directors of nursing who report complaints by professional nurses about boredom with their jobs.

Table 19
Complaints About Boredom With Their Jobs
(Among Nurses by Rated Bed Capacity in 1982)

	Rated Bed Capacity		
Response Category	132 to 246	247 to 382	383 to 2,500
Often	8.0	3.8	2.6
Sometimes	40.0	53.8	76.9
Never	52.0	42.3	20.5
	<u>100%</u>	<u>100%</u>	<u>100%</u>
	(n=25)	(n=26)	(n=39)

$\chi^2 = 9.45$ d.f. = 4 P = 0.05 Gamma = -0.35

Table 19 shows that the relationship between the proportion of directors of nursing reporting boredom among professional nurses and the rated bed capacity of hospitals is significant at the 0.05 level with a gamma of 0.35.

Table 20 shows that there is a relationship between the proportion of the directors of nursing reporting that professional nurses complain about boredom with their jobs and the teaching status of the hospital.

Table 20

**Complaints About Boredom With Their Jobs
(Among Nurses by Teaching Status of Hospital)**

Response Category	Teaching	Non-Teaching
Often	—	6.7
Sometimes	76.7	51.7
Never	23.3	41.7
	100%	100%
	(n=30)	(n=60)
$\chi^2 = 5.97$	d.f. = 2	P = 0.05
		Cramer's V = 0.26

(12) Complaints about the lack of meaningfulness of their tasks

Meaningfulness or significance would seldom have been asked of work in earlier work systems. But today, an increasing number of people feel it is an important attribute of a good job. In other words, they want to contribute, they want what they do to make a difference, and they want to see that their energy accomplishes something. This desire is generally what is behind a complaint about a lack of meaningfulness.

Table 21 examines the perceptions of the directors of personnel and of nursing and union representatives regarding such complaints. Here again, a majority report that employees make this complaint.

Table 21

Complaints About the Lack of Meaningfulness of Their Tasks

Response Category	A Director of Nursing		B Personnel Director		C Union Officer
	Professional Nurses	Non-Professional Nursing Staff	Medical Support Staff	Non-Medical Support Staff	Group C
Often	8.8	13.2	4.4	6.5	19.0
Sometimes	65.9	68.1	46.2	73.1	57.1
Never	25.3	18.7	49.5	20.4	23.9
	<u>100%</u>	<u>100%</u>	<u>100%</u>	<u>100%</u>	<u>100%</u>
	(n=91)	(n=91)	(n=91)	(n=93)	(n=184)

Conclusion

In most work settings today, including hospitals, the younger and more highly educated workers tend to have higher and different expectations of their work. They therefore tend to become dissatisfied with traditional jobs which are production line, highly supervised, or over-specialized, and which lack the important qualities of autonomy, learning, mobility, and meaningfulness. Thus it is not surprising that the largest proportion of respondents report that workers complain about the lack of these aspects in the jobs.

This means that, unless jobs are redesigned so that workers' capacities are better utilized and workers feel they have more say about their work, they will be dissatisfied, become less effective in their jobs, and be less willing to offer their services and take responsibility. This would have very costly consequences for hospitals.

3.3.3 Special Indicators of the Quality of Working Life

The third way we probed the state of QWL in hospitals was through a series of questions about what we regarded as indicators of job dissatisfaction: the number of work-related staff injuries, the cost of salary insurance paid out annually, staff complaints about their meals, the number of symptoms of stressful working conditions, the number of contractual grievances, and the number of cases of arbitration.

For each of these indicators and for each type of employee, a substantially larger percentage of each type of respondent reported an increase than a decrease. In many cases a clear majority reported no change. However, the fact that substantially more directors of nursing and personnel reported an increase in these indicators means there is a trend, albeit not a strong one (except in certain areas), toward dissatisfaction with working life among hospital employees.

The special cases of note are:

- a. The high percentage of directors of nursing (41.1%) from general hospitals who reported an increase in grievances among nurses.
- b. The high percentage (50%) of the directors of personnel in teaching hospitals who reported an increase in work-related staff injuries among non-medical support staff.
- c. The close relationship ($\chi^2 = 12.9$; P is greater than 0.01; Cramer's $V = 0.30$) between the percentage of directors of personnel reporting increases in stress symptoms and the percentage reporting increases in salary insurance paid out (absenteeism).

(13) The amount of salary insurance paid out annually

Salary insurance paid out seems to be a good and firm indicator of absenteeism. Table 22 shows that a much higher percentage of directors of nursing and personnel reported an increase than reported a decrease in the amount paid out, suggesting that in many hospitals there had been an increase in absenteeism over the past three years.

Table 22

The Amount of Salary Insurance (Sick Leave Insurance)
Paid Out Annually

Response Category	A Director of Nursing		B Personnel Director	
	Professional Nurses	Non-Professional Nursing Staff	Medical Support Staff	Non-Medical Support Staff
Decreased	10.8	7.3	10.1	9.0
Unchanged	50.8	47.3	48.1	46.2
Increased	38.5	45.5	41.8	44.9
	100%	100%	100%	100%
	(n=65)	(n=55)	(n=79)	(n=78)

Table 23 shows that there is a very strong relationship (significant at better than the 0.01 level) between the proportion of directors of nursing reporting increases in salary insurance and the population of the area.

Table 23

**The Amount of Salary Insurance (Sick Leave Insurance) Paid Annually
(Among Nurses by Population of City)**

Response Category	POPULATION				
	10,000	10,000 to 49,999	50,000 to 99,999	100,000 to 499,999	500,000
Decreased	57.1	6.7	—	5.6	7.1
Unchanged	28.6	40.0	72.7	61.1	42.9
Increased	14.3	53.3	27.3	33.3	50.0
	<u>100%</u>	<u>100%</u>	<u>100%</u>	<u>100%</u>	<u>100%</u>
	(n=7)	(n=15)	(n=11)	(n=18)	(n=14)
$\chi^2 = 21.53$ d.f. = 8 P = 0.01 Cramer's V = 0.41					

**(14) Complaints about the quality or quantity
of food provided at staff meals**

While it is probably not a powerful indicator of dissatisfaction (and may reflect a real decline in the quality of food because of economies) complaints have increased over the past three years for all categories of personnel, according to the directors who reported on such complaints.

Table 24

**Complaints About the Quality or Quantity of Food
Provided at Staff Meals**

Response Category	A Director of Nursing		B Personnel Director	
	Professional Nurses	Non-Professional Nursing Staff	Medical Support Staff	Non-Medical Support Staff
Decreased	10.8	6.7	6.8	7.9
Unchanged	66.2	69.3	73.9	77.5
Increased	23.0	24.0	19.3	14.6
	100%	100%	100%	100%
	(n=74)	(n=75)	(n=88)	(n=89)

(15) Staff reports of symptoms specifically
related to stressful working conditions

This refers to symptoms such as tension, anxiety and insomnia. Table 25 shows that a much higher proportion of directors of personnel and of nursing reported an increase than reported a decrease in such symptoms during the past three years. In fact, there were almost no reports of decrease. Symptoms of stress are probably also indicators of dissatisfaction.

Table 25

**Staff Reports of Symptoms Specifically Attributed
to Stressful Working Conditions**

Response Category	A Director of Nursing		B Personnel Director	
	Professional Nurses	Non-Professional Nursing Staff	Medical Support Staff	Non-Medical Support Staff
Decreased	—	—	—	1.2
Unchanged	64.8	77.5	73.1	69.1
Increased	35.2	22.5	26.9	29.6
	100%	100%	100%	100%
	(n=71)	(n=71)	(n=78)	(n=81)

When the amount of salary insurance paid out annually is related to the number of staff reports of such symptoms (that is, when we compare the proportion of directors reporting increases in both cases), we find that there is a very high correlation. As the salary insurance (or absenteeism) increases, so does the number of staff reports of stressful working conditions. This stands to reason; when workers find their work stressful, they are more likely to stay away from work. The easiest way to do this is to stay off sick, which would lead to an increased amount paid out in salary insurance.

Table 26 describes this relationship, which is both significant and strong.

Table 26

**Staff Reports of Symptoms Specifically Attributed to
Stressful Working Conditions
(Among Non-Medical Support Staff by Amount of Salary
Insurance Paid Out Annually)**

Response Category	Salary Insurance Paid Out Annually		
	Decreased	Unchanged	Increased
Decreased	—	3.1	—
Unchanged	85.7	87.5	53.1
Increased	14.3	9.4	46.9
	100%	100%	100%
	(n=7)	(n=32)	(n=32)
$\chi^2 = 12.92$ d.f. = 4 P = 0.01 Cramer's V = 0.30			

- (16) Work-related staff injuries
(back injuries, needle punctures, heat or
chemical burns, sprains, etc.)

The proportion of directors of nursing and of personnel reporting an increase in the number of such injuries is much larger than the proportion reporting a decrease, although the majority report no change. We interpret this to mean that in a substantial proportion of the hospitals, the respondents see an increase in such injuries. If what they see is a true indicator, it suggests an increase either in stress, in carelessness or in complaints. Safety has long been known to be associated with the degree to which the worker assumes responsibility and feels positive towards his or her work. Typically, as such attitudes improve, the number of accidents decreases. Thus, the number of such injuries is a good indicator of the feelings people have about their work.

Table 27

Work-Related Staff Injuries
(Back Injuries, Needle Punctures, Heat or Chemical Burns, Sprains, etc.)

Response Category	A Director of Nursing		B Personnel Director	
	Professional Nurses	Non-Professional Nursing Staff	Medical Support Staff	Non-Medical Support Staff
Decreased	11.0	7.8	8.3	10.5
Unchanged	58.5	59.7	72.6	59.3
Increased	30.5	32.5	19.0	30.2
	100%	100%	100%	100%
	(n=82)	(n=77)	(n=84)	(n=86)

When we control for the teaching status of the hospital and focus on the non-medical support staff, we find that a very high proportion of the directors of personnel in teaching hospitals report increases in such injuries (50%). It can be seen that there is a significant difference between teaching and non-teaching hospitals, and that the relationship between the variables is a strong one (see table 28).

Table 28

The Number of Work Related Staff Injuries
(Among Non-Medical Support Staff by Teaching Status)

Response Category	Teaching	Non-Teaching
Decreased	3.8	13.3
Unchanged	46.2	65.0
Increased	50.0	21.7
	100%	100%
	(n=26)	(n=60)
$\chi^2 = 7.46$		d.f. = 2
P = 0.02		Cramer's V = 0.29

(17) Grievances and arbitration cases

Two other indicators--the number of grievances related to contractual issues and the number of cases of arbitration resulting from unresolved grievances--point to the state of the quality of working life within hospitals. A substantial proportion of directors of nursing and personnel report an increase in grievances over the past three years. Their reports focus on grievances by nurses and grievances by non-medical support staff. An increase in the number of grievances suggests: (1) that problems relating to the contract are not resolved between the employee and his supervisor, and (2) that such problems have increased.

When a grievance goes to arbitration, it means that the grievance has not been resolved. Again, we find that the proportion of directors of nursing and personnel reporting an increase in the number of arbitration cases is largest with respect to the nurses and to the non-medical support staff.

Table 29

Grievances Related to Contractual Issues
(Among Nurses by Type of Hospital Care)

Response Category	Type of Hospital			
	General	Long Term	Mental Retardation	Psychiatric
Decreased	7.1	12.5	50.0	--
Unchanged	51.8	75.0	50.0	92.3
Increased	41.1	12.5	--	7.7
	100%	100%	100%	100%
	(n=56)	(n=8)	(n=2)	(n=13)
$\chi^2 = 14.66$ d.f. = 6 P = 0.02 Cramer's V = 0.30				

Table 30

Cases of Arbitration Resulting From Unresolved Grievances

Response Category	A Director of Nursing		B Personnel Director	
	Professional Nurses	Non-Professional Nursing Staff	Medical Support Staff	Non-Medical Support Staff
Decreased	9.2	2.8	7.1	7.1
Unchanged	72.4	91.5	81.0	72.9
Increased	18.4	5.6	11.9	20.0
	100%	100%	100%	100%
	(n=76)	(n=71)	(n=84)	(n=85)

Conclusion

Our findings suggest that over the past three years there has been a decline in the quality of working life in Canadian hospitals, as manifested by increases in indicators of stress, absenteeism, dissatisfaction and hostility.

4. CONCLUSIONS

As we noted in the Introduction, organizations in modern society are feeling strains resulting from changes in technology, in the expectations of workers, and in the demands made on them by an increasingly complex environment.

Hospitals may be particularly susceptible to such strains, since they have grown enormously, are highly labour intensive, and are very exposed to demands from the environment.

The findings from the survey substantiate the impression that symptoms of such strains are increasing in Canadian hospitals. Particularly among those workers who are least influenced by professional codes and ethics, there are clear symptoms of work dissatisfaction and absenteeism.

Hospitals are responding to these problems by introducing many organizational innovations: recruiting new kinds of staff specialists in human resource development, trying to create teams, and so on. Part Two of this report describes some of the innovations currently being attempted by Canadian hospitals.

These symptoms of strain and dissatisfaction indicate that hospitals need to redesign their work systems in ways that make jobs more satisfying to workers and make the organization more responsive to changing technology and environmental demands. A successful model for such changes can be found in the "quality of working life" redesign of offices, factories, and government departments. All over the world, managers, supervisors and workers have analyzed and redesigned their work organizations and achieved some remarkable gains in both worker satisfaction and productivity. There is every reason to believe that change programs based on sociotechnical redesigns, when modified to meet the needs of hospitals, could lead to important improvements.

The results of this survey clearly point to the need for considering such programs for Canadian hospitals, especially for those in the forefront of change, the teaching and large urban hospitals. Here, some opportunities should be created by responsible agencies to help hospitals diagnose their own needs, learn about useful models for change, and engage in change processes tailored to their particular technology and responsibilities.

1983

PART TWO: INNOVATIONS AND SOLUTIONS

by

Joan Kahn



FOREWORD

Innovations within a hospital organization (i.e., intra-hospital innovations), as well as those that entail the involvement of one or more health care institutions in the vicinity (i.e., inter-hospital innovations), may both be seen as representing a hospital's attempt to respond effectively to influences originating in the external environment. Hence, in Section One, some of the reported innovations will be classified and described from an environmental perspective, that is, according to the nature of the environmental influences that provoked them.

A second group of reported innovations (although also the result, directly or indirectly, of environmental influences) will be classified and described within an organizational perspective, that is, according to the nature of the organizational responses they exemplify. These will appear in Section Two.

Section Three will describe innovations that show that hospitals are aware of the necessary connection between employee satisfaction and hospital performance. New policies, programs, etc., that focus upon staff problems or staff needs will appear in this section of the report.

Finally, Section Four will consist of all reported innovations exemplifying such quality of working life principles as: (1) union-management collaboration; (2) role enrichment, cross-training, and multi-skilling; and (3) multi-disciplinary and multi-level activities.

The reader is asked to note the following:

- a. In some cases, innovations will be cited in more than one section if they seem to belong equally to two different categories. For example, "infection control nurse" appears in Section One under Quality Assurance, but reappears in Section Two under New Roles.
- b. Each cited innovation will be followed by a bracketed number (or numbers) referring the reader to the name, address, and telephone number of the particular hospital(s) reporting that innovation. A list of all such hospitals will appear in Appendix I, where each will be identified by its own number, as well as by a code letter indicating the type of service offered (i.e., "General" = G; "Long Term" = LT; "Mental Retardation Facility" = MR; and "Psychiatric" = P).
- c. In addition to the innovations reported by respondents to Part Two of the survey, some were also reported throughout Part One. Since we have guaranteed anonymity for all responses to Part One, however, we have refrained from indicating the identities of the particular hospitals from which these innovations were reported. Instead, all innovations derived from Part One will be distinguished from those derived from Part Two by means of the letter I.

- d. The appearance of an asterisk (*) following an innovation means that it will be described in greater detail in Section Four of the report, which deals with innovations reflecting quality of working life values and principles.
- e. An attempt has been made to adhere to the original wording used by respondents in describing their innovations. When changes were made, they were usually prompted by a need for either brevity or greater clarity.

SECTION ONE



INNOVATIONS CLASSIFIED ACCORDING TO THE NATURE OF THE ENVIRONMENTAL INFLUENCE THAT PROVOKED THEM

1. GOVERNMENT REGULATIONS THAT IMPOSE SIGNIFICANT RESTRICTIONS ON HOSPITAL OPERATING BUDGETS

The vast majority of Canadian hospitals cited the need to reduce costs. This is a major stimulant for innovations of all types. For some of the reported innovations, however, the matter of cost efficiency was given special emphasis, as in the following:

1.1 Cost Containment Committees, Departments, Programs, and Roles (General)

- Budget Control Committee (8.4)
- Budgetary Restriction Program (9.5)
- Cost Awareness Committee (3.6; 9.7)
- Cost Effectiveness Committee (3.8)
- Cost Effectiveness Program (6.8)
- Cost Management Committee (8.35)
- Cost Restraint Committee (3.3)
- Internal Audit Department (7.3)
- Multidisciplinary Committee (Administrative, Medical and Technical Personnel, chaired by Director of Finance)* (8.7)
- Multidisciplinary Utilization Review Committee* (4.5)
- Recovery Plan to decrease budget by 5% (9.8)
- Budget Control Clerk (6.8)

1.2 Cost Containment Committees or Programs (Specific)

- Energy Committee (5.3)
- Energy Management Program (5.7)
- Equipment Committee (1.3)

* All items followed by an asterisk reappear in Section Four as innovations that reflect quality of working life principles or values.

- . Laundry User Committee (1.3)
- . Menu Management Committee (10.4)
- . Product Evaluation Committee (1.3; 5.3; 10.4)
- . Products and Materials Evaluation Committee (9.7)

1.3 The Creation of Special Extended Care Departments in Acute Care Facilities

In order to make the most efficient use of human and technological resources, long-term patients formerly dispersed throughout various wards in the hospital are now being placed together in one area. This helps to free acute care beds and staff, and permits a more effective delivery of rehabilitation services to these long-term patients (3.3; 6.9; 8.3).

1.4. Patient Classification Schemes

Insofar as patient classification schemes attempt to group patients on the basis of the amount of care they will require in hospital, they reflect the hospital's awareness that costly human resources (nurses, etc.) must be carefully allocated in order to deliver required services in the most efficient way possible. Four hospitals reported this innovation (4.5; 5.3; 5.7; 6.5).

1.5 Day Care Units

The establishment of day care units was widely cited as an innovation by Canadian hospitals, and was justified on the basis of (a) the need to reduce costs, and (b) the shortage of hospital beds. Examples include:

- . Day Surgery (2.1; 2.4; 2.5; 4.4; 5.2; 5.3; 8.35; 8.7)
- . Psychiatric Day Care (4.2; 5.3; 7.6; 8.0)
- . Geriatric Day Care (6.4; 10.1)
- . Pediatric Day Care (3.2; 8.1)
- . Rehabilitative Day Care (Physiotherapy, Occupational Therapy, Speech Therapy) (3.7)
- . Self-Care Dialysis Unit (4.3)
- . Diabetic Day Care (6.0)

1.6 Specific Cost Reduction Measures

- . A total change was made in the heating plant to save energy and to benefit from the law pertaining to immovable machinery. (10.2)

- Change in the heating system from oil to wood. (9.0).
- Change from one brand of X-ray film to another, which allowed a \$30,000 saving in the hospital budget. (4.8)
- Change from hot to cold food production system. (9.0)
- Introduction of disposable trays on the nursing floors to enable the hospital to reduce the number of required staff. (4.5)
- The system of distributing supplies has been changed from an exchange cart system to a "topping-up" system with employees taking supplies to the nursing units. This alleviated the problem of over-ordering and wastage. (6.8)
- Cessation of breakfast services by the cafeteria. Breakfast service was not much used and there had been an increase in the number and type of vending machines. (8.35)

1.7 Job Sharing

- The employee group was not specified. (5.7)

2. THE "TECHNOLOGICAL IMPERATIVE" TO PROVIDE "STATE OF THE ART" PATIENT CARE

The proliferation of technology during the past three decades has had an enormous impact on organizations of all types. In response to this development, hospitals have innovated by acquiring biomedical technology and non-medical technology, and by implementing in-service staff training to assure that the necessary levels of technical skill are met.

2.1 Innovations Involving Biomedical Technology

2.1.1 New Organizational Structures

In response to new developments in biomedical technology, hospitals have created various departments, laboratories, services, and roles. These include:

- Biomedical Engineering Department (6.6)
- Bone Marrow Transplant Service (8.4)
- Cardiopulmonary Department (5.3)
- Specialized Heart Clinic for patients with implanted pacemakers offering stress testing, echocardiography, holter monitoring, and a pacemaker clinic (4.8)

- . Clinical Engineering Department (7.1)
- . CT Scanning Department (5.3)
- . Echography Department (5.3)
- . Laboratory to study the behaviour of foreign materials in the organism (9.6)
- . Nuclear Medicine Department (9.6)
- . Department of Respiratory Technology (7.8; 8.0)
- . Cybernetics Committee* (8.35)
- . Director of Technical Resources for coordinating biomedical technical resources (4.7)

2.1.2 Recent Purchases of Biomedical Technology

Hospital administrators were asked to indicate what were the most expensive examples of biomedical technology (used either for diagnostic, therapeutic, or rehabilitative purposes) their respective hospitals had acquired within the past few years. From a total of 97 responses, the following information was obtained:

- . Nuclear Magnetic Resonance Apparatus: acquired by one responding hospital (4.2)
- . CT Scanner: acquired by 23 responding hospitals (1.0; 1.2; 1.3; 1.5; 1.7; 1.8; 3.1; 3.29; 4.3; 4.5; 4.8; 5.2; 5.3; 5.7; 5.8; 6.2; 7.1; 7.4; 8.2; 8.3; 8.35; 8.4; 8.8)
- . Ultrasound Equipment: acquired by 37 responding hospitals (1.2; 1.6; 1.8; 1.9; 2.2; 2.5; 2.9; 3.3; 3.5; 3.7; 4.4; 4.5; 4.9; 5.0; 5.1; 5.2; 5.7; 5.8; 6.1; 6.7; 7.0; 7.2; 7.5; 7.6; 7.7; 7.9; 8.6; 8.9; 9.0; 9.5; 9.6; 9.7; 9.8; 9.9; 10.0; 10.2)
- . Fluoroscopy Equipment: acquired by 12 responding hospitals (1.1; 1.9; 2.2; 2.5; 2.7; 3.0; 3.2; 3.29; 7.2; 8.0; 8.5; 8.8)
- . Gamma Camera: acquired by 11 responding hospitals (1.8; 2.7; 3.0; 3.1; 3.3; 4.8; 5.1; 6.0; 7.9; 9.6; 9.9; 10.3)
- . Laser Beam Machine: acquired by 1 responding hospital (9.0)
- . Oncology Radiotherapy Equipment: acquired by 2 responding hospitals (3.29; 8.4)

- Linear Accelerator: acquired by 1 responding hospital (6.3)

2.2 Innovations Involving Non-Medical Technology

2.2.1 Computer Technology

Several hospitals reported the emergence of new committees, departments, services, and roles involving the use of computers. These include:

- Cybernetics Committee* (8.35)
- Computer Steering Committee (6.8)
- Computer Services Department (8.4)
- Computer Systems Development Department (3.2)
- Coordinator of Computer Services (4.7)
- Computer Consultant (6.8)
- Word Processing Study Group (8.35)

Hospital administrators were asked whether computers were used in their hospitals, and if so, for what function. Ninety-five (95) hospitals responded to this question. Eighty-eight (92.6%) reported that they used computers for at least one of the functions listed below:

- Scheduling admissions and discharges: cited by 16 hospitals (16.9%)
- Scheduling surgery: cited by 3 hospitals (3.2%)
- Scheduling appointments with doctors: cited by 3 hospitals (3.2%)
- Processing medical records: cited by 31 hospitals (32.6%)
- Processing prescriptions by pharmacy: cited by 13 hospitals (13.7%)
- Employee payroll: cited by 83 hospitals (87.4%)
- Accounts payable and receivable: cited by 76 hospitals (80.0%)
- Monitoring inventory of equipment and supplies: cited by 54 hospitals (56.8%)
- Biochemical analysis: cited by 40 hospitals (42.1%)

- . Hemotological analysis: cited by 37 hospitals (38.9%)
- . Diagnostic technology: cited by 34 hospitals (35.9%)
- . Therapeutic technology: cited by 8 hospitals (8.4%)
- . Monitoring equipment: cited by 30 hospitals (31.6%)
- . On-line access to a remote computer: cited by 33 hospitals (34.7%)

2.2.2 Telecommunications, Paging Systems, etc.

a. Telecommunications

- . Change from Bell system to hospital interconnection system (9.0)
- . Telephone system throughout the hospital was changed from a PBX 701 to a computerized SL-1 system. (6.8)

b. Other

- . The PA system was enlarged to include the residence and all areas of the hospital, and was wired so that the organ, records, tapes and chronabell can be heard over it on special occasions. (6.8)
- . Mobile radio paging system (6.8)
- . Hospital interconnection system (computerized) (6.8; 9.0)
- . Central dictating system (6.8)

2.3 In-Service Staff Education

In order to maintain the level of education and skill required to deliver "state of the art" care, hospitals have developed a number of educational and training programs or departments. These fall into two groups: (1) General, and (2) Specialized.

2.3.1 General

- . Hospital Education Department (6.4; 6.5)
- . In-Service Education (8.9)
- . Staff Development and Education Department (8.1)
- . Staff Training Program (6.7; 9.6; 9.7)

2.3.2 Specialized

- . CT Scanning Education* (4.8)
- . CPR Training Program (6.6; 6.8)
- . Drug Literature Retrieval Program (4.8)
- . Critical Care Nursing Program (7.1)
- . Specialized Education for Nurses and Nursing Assistants (8.4)

3. INNOVATIONS THAT ARE RESPONSES TO VARIOUS KINDS OF COMMUNITY DEMANDS

Communities that surround hospitals and are served by them have certain expectations concerning the type of service they can reasonably expect. In brief, they expect services that are: (1) quality assured, (2) integrated at the level of patient care, (3) designed for specific problems, whether physical, psychological, or social, and (4) addressed to specific needs, such as the need for geriatric care, rehabilitation and follow-up, palliative care, and special education.

3.1 Community Demand for Services that are Quality Assured with Respect to Specific Technologies and Skills

Widely represented among reported innovations was the emergence of quality assurance activities. These include the creation of new committees, departments, programs or roles whose general task is to foster evaluation measures for various types of patient care activities carried out in the hospital. Some of the reported innovations in this area focus on specific functions such as:

- . Infection control
- . Monitoring the dispensing, usage, or effects of pharmaceuticals
- . Monitoring special medical, surgical, and emergency procedures, and
- . Monitoring special paramedical or support functions

3.1.1 General Quality Assurance Innovations

Committees:

- . Administrative Service Audit Committee* (7.0)
- . Quality Assurance Committee (9.7)

- . Treatment Evaluation Committee (Nursing) (8.7)

Departments:

- . Quality Assurance Department (3.6; 5.2)

Programs:

- . Performance Appraisal Program* (3.2)

Roles:

- . Audit Nurse (2.1)
- . Quality Assurance Coordinator (5.8; 6.6; 6.7)
- . Quality Assurance Monitor (8.3)
- . Quality Assurance Discharge Planning Officer* (2.4)
- . Quality Assurance Nurse (2.5; 4.9)

3.1.2 Specific Quality Assurance Innovations

Infection Control:

- . Infection Control Program (8.0)
- . Infection Control Service (4.8)
- . Infection Control Nurse (8.3)
- . Infection Control Practitioner (6.8)

Monitoring the Delivery of Pharmacotherapy to Patients:

- . Adverse Drug Reaction Program (4.2)
- . Audit of Drug Blood Level Utilization (4.8)
- . Clinical Pharmacokinetic Service (4.8)
- . Clinical Toxicology Service (4.8)
- . Medication System Study Group* (8.35)
- . Unit Dose Pharmacy Programs (2.5; 2.7; 3.6; 4.3; 6.2; 6.7)

Monitoring Special Medical, Surgical, and Emergency Procedures:

- . Perinatal Mortality Committee (7.8)

- Tissue Committee (6.6; 7.8)
- Tumour Committee (7.8)
- CPR Committee (3.1)
- CPR Program (6.8)
- Emergency Care Committee (6.8)
- CPR Team (8.35)

Monitoring Dietary Functions:

The introduction of special trays which keep food at its serving temperature has greatly reduced patients' complaints about cold meals (7.3).

3.2 Community Demand for Services that are Integrated at the Level of Patient Care

A number of hospitals reported innovations that reflect an attempt to integrate patient-centred activities, and thereby improve the general quality of patient care. Cited among the reasons for adopting these innovations were the following concerns: (1) how to better deal with patient complaints, (2) how to improve communication between departments involved directly or indirectly with patient care, and (3) how to improve communication between patients and health care workers. Many of the reported innovations involved the formation of interdisciplinary teams, committees, etc., and therefore exemplify quality of working life principles.

Other attempts to address these concerns included the creation of special "patient advocacy" roles and the development of activities that address themselves to the issue of patients' rights.

3.2.1 Committees, Teams, Roles, Other

Committees:

- Consumer Service Committee (committee of the Board of Directors) (5.7)
- Patient Care Assessment Committee (8.35)
- Patient Care Committee (2.3; 6.8; 7.1; 7.9; 8.5; 10.4)*

Teams:

- Individual Program Plan Teams (3.9)
- Quality of Care Team on each ward (9.7)

Roles:

- Patient Ombudsman (8.3)
- Patient Representative (3.29; 6.7)

Other:

- An Ad Hoc Patient Consent Committee was established to revise all hospital consent forms, as well as the policies and procedures pertaining to each consent. The review process lasted almost two years, and the end result was the development of a Consent Manual. The manual contains a description of the types of consent, pertinent legislation governing consent, samples of the revised forms, and their corresponding policies and procedures. Its purpose is to help staff deal with the recurring problems of obtaining valid, informed consent (4.8).
- Publication of a "Statement of Principles", a patient's guide to her or his rights and responsibilities (8.3).

3.3 Community Demand for Services Organized Around Specific Problems and Needs

Many innovations reported by hospitals across the country involve the creation of highly specialized programs, committees, clinics and roles that answer to a wide variety of specific problems--physical, psychological, or social.

Other innovations are best understood as responses to community needs which arise from such environmental factors as: (1) an aging population, and (2) changing patterns of family structure, function, and values; e.g., those manifested by nuclear, two-income families. These two factors generate the need for: (1) geriatric services; (2) the early and effective reintegration of a sick family member into society through rehabilitation and follow-up services; and (3) the provision of palliative care for dying family members. Finally, the complexity of modern health care and the recognition of the importance of prevention create a need for specific types of patient and family education.

3.3.1 Innovations Organized Around Specific Problems

Physical:

- Cancer Chemotherapy Program (7.9)
- Dental and Ophthalmology Clinics to serve patients with cancer of the head and neck (6.3)
- Oncology (Chemotherapy) Clinic (7.8)
- Oncology Clinic (8.7)

- Oncology Day Centre (8.35)
- Oncology Unit (8.3)
- Oncology Teaching Nurse (7.8)
- Oncology Liaison Nurse (8.3)
- Cystic Fibrosis Clinic (5.7)
- Diabetes Clinic (10.0)
- Hemophilia Clinic (5.7)
- Multiple Sclerosis Clinic and Seating Clinic (5.7)
- Psoriasis Clinic (6.0)
- Tropical Disease Unit (8.4)
- Audiology Clinic (7.8)
- Audiology Department (8.0)
- Audiology-Speech Committee (8.35)
- Hearing Loss and/or Prevention Program for Children (8.0)
- Amputee Clinic (5.1)
- Foot Care Clinic (5.1)
- Back Awareness Program (6.4)
- Chest Clinic (6.0)
- Eye Clinic for Sports Eye Injuries (6.6)
- Neuro-Endocrine Clinic (4.7)
- Otorhinolaryngology Department (1.8)
- Sports Medicine Clinic (8.35)
- Pain Clinic (1.7)
- Recurrent Abdominal Pain Clinic (8.35)
- Stress Testing Unit (4.4)
- Adult Burn Centre (6.6)

- Burn Unit (3.6)
- Burn Unit (7.1)
- Consolidated Intensive Care Unit (8.35)
- Intensive Care Unit (9.3)
- Rapid Consultation Service (Medical Services) to provide for urgent but non-emergency services (7.3)
- Stroke Team* (8.3)
- Trauma Unit (10.0)
- Ante-Partum Outreach Program (3.29)
- Fetal Assessment Unit (3.29)
- Neonatal Intensive Care Unit (8.3)
- Perinatology Program (4.7)
- Neonatology Program (5.7)

Psychological:

- Community Mental Health Centre (4.5)
- Pedopsychiatric Clinic (8.9)
- Teenage Stutterer Group Program (8.0)

Social:

- Addiction Assessment Service (3.7)
- Alcohol and Drug Abuse Day Care Program (3.8)
- Child Abuse Committee (7.2)
- Child Protection Committee (8.35)
- Family Planning Clinic (10.0)
- Options for Youth (chemical abuse program) (6.0)
- Single Parent Prenatal Group (8.0)
- Unmarried Mothers' Association (8.0)

3.3.2 Innovations Organized Around Specific Needs

The Need for Geriatric Services:

General -

- Geriatric Service (8.2)
- Geriatric Service Program (10.3)
- Multidisciplinary Community Geriatric Assessment Unit* (8.2)
- Geriatric Care Unit (8.3)
- Geriatric Care Program (8.5)
- Geriatric Care Team* (8.5)
- Geriatric Assessment Team (8.4)

Specific -

- Assisted Independent Living Project for the elderly (6.6)
- Recycling of Hearing Aids Program for senior citizens (8.0)

Special Roles -

- Clinical Nurse Specialist in Geriatrics (7.3)
- Nurse Geriatric Specialist (6.4)
- Psychogeriatric Nurse (6.4)

The Need for Rehabilitation and/or Follow-up Services:

General -

- Physiotherapy Outpatient Program (6.8)
- Physiotherapy Rehabilitation Program (5.7)
- Occupational Therapy Rehabilitation Program (5.7)
- Multidisciplinary Committee for Patients with Potential for Functional Rehabilitation* (10.1)

Specific -

- Rehabilitation Team for Extended Care Patients* (6.9)

- Physical Rehabilitation Service for Chronic Care Patients and Outpatients (9.2)
- Rehabilitation for Multi-Handicapped Children (Physiotherapy, Speech Therapy, and Occupational Therapy) (2.5)
- Speech and Hearing Therapy Program for Children (8.7)
- Department of Audiology and Speech (8.0)
- Rehabilitation Program in Audiology (5.7)
- Plastic Surgery Rehabilitation (2.4)
- Total Parenteral Nutrition - Home Care Program (4.8)
- Chronic Respiratory Rehabilitation Program (1.4)
- Follow-up Program for Asthmatics (8.1)
- Multidisciplinary Cardiac Rehabilitation Team* (8.3)
- Post-Cardiac Care Program (7.8)
- Follow-up Program for Diabetics (8.1)
- Rehabilitation Units for developmentally handicapped teenagers* (3.9)
- Mental Health Outreach Program (5.3)
- Psychiatric Rehabilitation Program (4.2)
- Rehabilitation Program for Mentally Retarded (4.2)
- Creation of a Vocational Workshop (3.9)
- Prevocational and Basic Life Skills Training Centre (3.9)
- Basic Employment Training (B.E.T.) Program (3.9)

Special Role -

- Nurse specializing in Rehabilitative Medicine (6.4)

The Need for Palliative Care:

- Palliative Care Clinic (5.1)
- Palliative Care Unit Committee (10.4)
- Palliative Care Committee (7.2)

- Palliative Care Service (3.8)
- Palliative Care Consultative Service* (4.9)
- Palliative Care Team* (4.3)
- Palliative Care Unit (1.3; 3.6; 5.8)

Special Role -

- Palliative Care Coordinator (6.0)

The Need for Patient and Family Education:

A number of hospitals reported innovations that dealt specifically with educational needs of patients and their families. In some cases, hospitals indicated that improved patient education contributes significantly towards better rehabilitation, and thus ultimately helps bring about a decrease in hospital admissions. These innovations have been divided into two types, general and specific.

General -

- Patient Education Advisory Committee (3.1)
- Patient Teaching Program for Inpatients and Outpatients (2.8)

Specific -

- Coronary Rehabilitation Education (6.0)
- Post-Coronary Teaching Program (5.2)
- "Hope and Cope" Outreach Program for Cancer Patients* (8.3)
- Interdisciplinary Education Program for Patients with Chronic Obstructive Lung Disease* (4.7)
- Stomatherapy Program (4.8)
- Outpatient Diet Counselling (7.8)
- Diabetic Teaching (8.0)
- Perinatal Program (8.7)
- Support Program for Parents of Premature Infants (4.7)
- Behaviour Management Clinic for parents of mentally retarded patients (4.2)



SECTION TWO

INNOVATIONS CLASSIFIED ACCORDING TO THE NATURE OF THE ORGANIZATION'S RESPONSE TO ENVIRONMENTAL INFLUENCES

A hospital's reaction or response to environmental influences is evidenced by the variety of forms or structures it creates as a consequence of those influences. In Section Two, reported innovations have been described in terms of the "location" of the innovation. These include (1) boundary-maintenance innovations (which occur on the border between the hospital and the community), (2) intra-organizational innovations (which occur within the hospital itself), and (3) inter-organizational innovations (which occur between the hospital and other health care institutions in the vicinity).

1. BOUNDARY MAINTENANCE INNOVATIONS

The term "boundary maintenance" refers to all measures that an organization must take in order to control the quantity and rate of its "inputs" and "outputs", and in order to maintain the integrity of its goals in the face of potentially disruptive environmental influences. It is useful to think of the boundary of an organization as its skin: ideally impermeable to harmful elements from without, but capable of absorbing those elements which will permit it to survive and thrive; able to retain the elements it requires, but also able to release other elements back into the environment when necessary. For a hospital, boundary maintenance includes (1) all activities concerning admissions and discharges, (2) all advisory activities that deal with how the hospital can adapt to changes in the environment, and (3) all public relations activities, by means of which the hospital attempts to maintain good relations with the community it serves, as well as to react appropriately to patient complaints, media criticism, etc.

1.1 Innovations Pertaining to Admissions and Discharges

Most of the innovations in this area were explained on the basis of the following principles: (a) to avoid admitting patients whose needs do not match the type of service the hospital offers; (b) to avoid unnecessary re-admissions; and (c) to decrease the average length of patient stay. These principles, of course, have implications for cost efficiency as well as organizational effectiveness. Examples of these kinds of innovations include:

- Creation of an Admission-Discharge Department (2.7)
- Creation of a Discharge and Planning Unit (1.3)
- Creation of an Alternate Care Committee: Due to pressure on in-patient beds and the fact that many patients come from many miles away, this committee was formed to investigate the possibility of placing out-of-town residents in hotels and motels, and yet providing them with health services (diagnostic and therapeutic) as out-patients (1.2)
- Creation of the role of Discharge Planner (6.9)

- . Creation of the Role of Discharge Planning Officer (7.1)

1.2 **Advisory Activities Directed at the Hospital's Needs to Adapt to Environmental Changes**

Executive directors are faced daily with numerous short-term or long-term decisions to be made in response to new demands and pressures placed upon the hospital by changing environmental factors. In some cases, external advisors or consultants are brought in to help in this process. In other cases, the hospital fulfills this advisory function within its own organization. Innovations involving this advisory function include:

- . Planning Committee of the board of directors (6.8)
- . Consulting Committee to the executive director, consisting of the consultant on administrative procedures and the executive board (9.5)
- . Administrative Advisory Committee to the administrator, consisting of the assistant administrator, medical director, director of nursing, supervisor of physical medicine, director of staff development, comptroller and director of personnel (6.8)
- . Appointment of a Consultant in Administrative Procedures to the executive director (9.5)
- . Protocol Review Committee (with representation from the medical staff, nursing, diagnostic services and administration). **Reason:** The need to develop and review protocols with regard to government regulations pertaining to the delegation of medical and nursing acts (8.35)
- . Development Projects Review Committee (with representation from the medical staff, non-medical professionals and administration). **Reason:** The need to develop objective criteria by which proposals for development may be evaluated with respect to their soundness, feasibility, relationship to existing programs, costs, benefit, and priority within the institution and the region; to provide advice and assistance to individuals in the preparation of proposals for development; to review proposals and make recommendations to the executive committee (8.35)
- . The interdepartmental advisory committee consisting of 8 to 10 middle management representatives chaired by the vice-president of finance and administration was established. **Reason:** To address the deficit by recommending cost-restraint measures and to suggest profit-making ventures

1.3 Innovations Involving Public Relations

- Public Relations Department (6.5; 6.7; I)
- Public Relations Program (9.6)
- Appointment of a Public Relations Director (5.3; 7.4)
- Distribution of a Quarterly Newsletter (7.3)

2. INTRA-ORGANIZATIONAL INNOVATIONS

Intra-organizational innovations include the following types:

- a. Innovations having system-wide implications
- b. Amalgamation (centralization) of authority and/or services
- c. Decentralization of authority and/or services
- d. Creation of new roles
- e. Changes in scheduling
- f. "Vertical integration" vs "contracting out"
- g. Phasing out

2.1 Innovations Having System-Wide Implications

2.1.1 Change in Hospital Goal

- From acute-care to long-term care (9.5; I)
- From custodial care to acute, active, mental health care (I)
- From chronic care to general rehabilitation (6.8). The name of the hospital for all but legal purposes was changed.

2.1.2 Change in Organization Chart

- The chart outlines the administrative hierarchy and at the same time reorganizes the professional services to make them more coherent and effective. **Reason:** Putting the hospital under a citizen's board was the major factor. It was also felt that a restructuring of the organization was needed to more effectively respond to the changes in the broader mental health system. The greatest challenge was to transform the hospital into a dynamic rehabilitation-oriented centre of psychiatric care. (2.6)

- . The chart was revised so that the medical director and the director of staff development were responsible for some departments, and the assistant administrator became responsible more for the "service" areas of the hospital. **Reason:** The change in the medical staff organization seemed an appropriate time to make a change in the organization chart. We were also hiring a new director of staff development, so were able to change the supervision of the librarians. At the same time, the assistant administrator had a little more experience in the administration area of the health care field. (6.8)
- . Organization chart was revised because too many people were reporting to executive director. (7.7)
- . Hospital decentralized reorganization: with the appointment of a new executive director, a more functional organization was established, with five positions reporting to the executive director rather than sixteen. **Reason:** Lack of information flow; stagnant organization; management philosophy of new executive director. (4.9)

2.1.3 Change in Committee Structure

- . There was a complete revision of committee structure within the facility. **Reason:** There was concern regarding the lack of authority below the level of the administrator, especially with regard to planning. Also, there was a lack of interdepartmental communication. (3.9)

2.1.4 Change in Information System

- . A Forms Committee was established to monitor new forms (or form changes) in relation to the overall hospital information system's design, and to achieve quality with maximum economy in the production of forms. **Reason:** There was a need for better screening and coordination, as well as a need to weed out slow moving or outdated forms. (2.2)

2.2 Amalgamation (Centralization) of Authority and/or Services

- . A number of hospitals reported innovations that involved the amalgamation or centralization of formerly differentiated services, functions, departments, etc. In many of these cases, there was also a redistribution of authority. This group of innovations has been divided into those that involve medical and paramedical functions, and those that involve non-medical functions.

2.2.1 Medical and Paramedical Functions

- a. The X-Ray Department was renovated and coordinated with the Health Records Department, the latter typing the reports and doing the bookkeeping and filing. The radiologist was asked to come once a week to read the X-Rays and dictate the reports. **Reason:** The department was getting busier, many X-rays were read late, and some reports were missing. (6.8)
- b. A pre-operative testing area was created. Patients now come to the Radiology Department and have their ECG, blood, and X-ray done in one area. **Reason:** There were too many inconveniences to patients before this change was made (i.e., going to Lab, ECG, Radiology, etc.). This eliminated needless delays, and resulted in a shortened patient stay. (4.8)
- c. Several small services were regrouped under the authority of service directors who were already in place. The following services were grouped together:
 - . Nuclear Medicine with Radiology
 - . Cytology with Anatomic-Pathology
 - . ENG and ECG under the authority of the records director

Reason: To regroup people who didn't seem to belong to any department, to assure better control of these services, and to raise efficiency. (9.5)
- d. Combined pediatric test centre and the clinical investigation unit. **Reason:** To prevent unnecessary admissions, to conserve resources, to develop more ambulatory diagnostic and treatment service and to meet the community's need for specialized pediatric, diagnostic and ambulatory testing. (8.35)
- e. Fusion of Central Service with Surgery Ward. **Reason:** To better control sterilization and distribution services, and to improve communication and cooperation. (8.7)
- f. The combination of ECG and EEG Departments. **Reason:** These services had enough in common that their combination seemed appropriate, particularly when one of the department heads retires. (7.1)
- g. In the Cardiology Department, the Pulmonary Care Unit and the Coronary Care Unit now have the same manager. Also, the Intensive Care Unit and Surgery have the same manager. (9.7)

- h. In several specialty units, the patient care co-ordinator (head nurse) role has been deleted and the unit has been joined with another unit under one administrative coordinator. The patient care coordinator to these units has been replaced by an assistant care coordinator. This change occurred in the following units:
- . The Recovery Room was placed administratively under the patient care coordinator of the O.R. (Operating Room).
 - . The High Risk Ante/Post-Partum Obstetrical Unit was placed under jurisdiction of the patient care coordinator of Labour/Delivery.
 - . The Normal Post-Partum and Newborn Nursery was amalgamated under one patient care coordinator to more appropriately promote the combined mother/baby concept developed for this unit.

These units were soon afterward relabelled, however, with separate patient care coordinators and staff.

Reason: Working relationships were not always conducive to good patient care; communication was sometimes a problem between the areas. (6.7)

- i. Nursing supervision in intensive, intermediate and normal nursing is now under the direction of one head nurse. **Reason:** Because of volume, one supervisor is better able to provide for continuity of direction and better planning for staffing and other resources. (3.29)
- j. The responsibility for the nurse staffing system and quality monitoring system has been combined under the staffing co-ordinator. **Reason:** To ensure that critical decisions regarding staff can be made as quickly as possible. (3.29)
- k. Eight nursing services were combined into four. **Reason:** Budgetary constraints. (4.8)
- l. Human Resource Management was centralized in the Nursing Department. (9.7)
- m. Two staff health services were amalgamated. One had served professional staff and the other, non-professional staff. **Reason:** Due to closure of the School of Nursing, students were no longer living in residence; needed space would be obtained for other hospital activities; reduction of budgets would be achieved. (8.4)

- n. Centralization under one manager occurred for the following departments: Occupational Therapy, Speech Therapy, Physiotherapy, and Children's Medical Services. Prior to the centralization, there were four department heads, each in charge of his or her own functional area. Under the new organization, one individual will work with the medical director of rehabilitation to plan and control all four functional areas. Reason: A problem existed with the coordination of the four functional groups in terms of patient planning and liaison with the medical director in charge of all four functional areas. (2.5)
- o. Combination of Vocational and Recreational Services to create a new department: Rehabilitation Services. The new department includes Occupational Therapy, Rehabilitation Counselling, Industrial Therapy Workshop, Recreation Department and the Hospital School. The department is headed by an occupational therapist. Reason: To more closely coordinate the various services with a cooperative approach. (4.2)
- p. Fusion of Occupational Therapy and Physiotherapy through the creation of a Rehabilitation Service. Reason: The two fused services have similar goals. (9.9)
- q. The creation of a Centralized Physical Rehabilitation Service for the following departments: Physiotherapy, Occupational Therapy, Orthophony, and Audiology. Reason: To better coordinate the service, develop joint care programs, and foster a multidisciplinary approach*. (9.7)
- r. There was an administrative fusion of rehabilitation services, comprising Inhalation Therapy, Audiology-Orthophony, Physiotherapy, and Electrocardiography, all placed under one coordinator. Reason: There had been a duplication of activity between ECG and Inhalation Therapy; there was a need for an integrated approach to patient care. (8.7)
- s. Admitting and Medical Records were combined. Reason: This was done to save money and occurred with the retirement of one of the department heads. It has worked extremely well. (1.2)
- t. Medical Records, Admitting and Discharge, and Switchboard were centralized into the Department of Central Information Services. Reason: Organizational changes, plus identification of improved service possibilities through centralization. (2.1)
- u. The roles in the Health Record Department were re-organized and modified, and the staff was increased to cover the Central Dictating Department and the coordination of the Radiology Department. Reason: Since the medical staff was re-organized, the work has increased and more staff was needed. (6.8)

- v. The role of the Staff Development Department has been modified and the librarian and the infection control practitioner report to the director. **Reason:** Following the re-organization of the medical staff, the Staff Development Department became involved in staff education in all departments, and the increased workload necessitated an increase in Staff (i.e., the addition of a nurse educator). (6.8)
- w. The medical suite and medical director's office were renovated and coordinated with Reservations. **Reason:** This allows for better communication between the medical director and reservation officer. (6.8)
- x. Director of professional services role was changed to director of hospital and professional services. **Reason:** Budgetary restraints caused the administrative centralization of these two services. (8.9)
- y. A Pharmacy-Nutrition Committee was formed to analyze medication use, to study natural substitutes and to motivate multidisciplinary teams*. (10.4)
- z. A Nursing/Pharmacy Committee was established to provide for better communication and problem solving between the two areas. (3.29)

2.2.2 Non-Medical Functions

- a. Central Supply Room, Stores, and Messenger Services were centralized into Department of Supply Processing and Distribution. **Reason:** Identification of improved service possibilities through centralization. (2.1)
- b. Food production was centralized. (9.8)
- c. Food distribution and dishwashing were centralized (9.9)
- d. Central Service and Linen departments were combined in the first steps of a coordinated materials management approach. (6.7)
- e. Materials Management, Admitting, Switchboard, and EDP (Electronic Data Processing) departments were transferred from the Financial Services Division to the Hospital Services Division. These departments report to the assistant executive director, Hospital Services, instead of reporting to the chief financial officer (formerly assistant executive director, Financial Services). **Reason:** The Financial Services Division was to concentrate on financial concerns; non-financial services would be better managed by a department that didn't have to devote its resources to financial matters. (7.3)
- f. Fusion of Accounting and Collection departments. **Reason:** To allow employees to perform multiple tasks*. (9.9)

- g. Centralization of Purchasing, Personnel, and Accounts departments. Reason: Acquisition of another care facility eight miles away. (2.0)
 - h. Creation of a Department of Materials Management; involved a merger of Central Supply Room, Purchasing, Stores, and Transportation. Reason: Problems with inventory levels; the need for better control of consumables; to foster better exchange systems (supplies, linen, etc.); to enhance transportation between two sites; to foster a better use of personnel. (5.0)
 - i. Creation of SPD (Supplies, Processing and Distribution) Department to include Purchasing, Stores, CSR (Central Supply Room), Printing, Laundry, Processing, and Distribution. (7.8)
 - j. Fusion of Stores and Purchase departments into Provision Department. Reason: Fusion was necessary to harmonize application of political, administrative, and labour rules. (9.9)
 - k. The following roles were amalgamated:
 - . Director of Personnel Services, and personnel manager
 - . Staffing assistant and personnel counsellor
 - . Secretary to the director, Personnel Services, and the personnel receptionist
 - . Coordinator of educational services and assistant coordinator of educational services
- Reason: Attrition of certain employees; budget restraints. (7.3)

2.3 Decentralization of Authority and/or Services

Decentralization refers to the extent to which services and/or authority are extended (i.e., decentralized) throughout the organizational hierarchy. Decentralization is strongly related to the concept of employee participation in decision making. The greater the decentralization, the greater the extent to which rank-and-file employees can participate in (and accept responsibility for) decisions concerning their jobs and the future of the organization. Innovations involving decentralization have been reported for the following functions.

2.3.1 Medical and Paramedical functions

a. Nursing

- . The nursing concept of the operating room was reorganized. As a result, authority was decentralized to theatre coordinators who are responsible for the safe and efficient management of patient care and coordination with medical staff. (3.2)

- The Department of Nursing was decentralized into four major services, each of which became the responsibility of a clinical manager who reported to the director of nursing. The director of nursing in turn reported to the associate executive director. The patient care coordinator (head nurse) was responsible and accountable for provision of quality patient care, and for the appropriate use of human and material resources. **Reason:** Much of the authority and responsibility rested with the supervisors and director of nursing. (4.7)
- There was a decentralization of authority, responsibility and accountability to the unit level. A patient care coordinator assumed "on-call" duty for the evenings, nights, and weekends. **Reason:** There had been an inappropriate use of nursing office supervisors, who were primarily used as staffing clerks and "gofers" for their departments. There was a corresponding lack of budget responsibility and control at the user level, and head nurses had not been assuming control or responsibility for their units on a 24-hour basis. Moreover, too many levels of administrative staff created problems in communication. (6.7)
- Decentralization in general administration has been in progress during the past year. All department managers, including head nurses or nurse managers (as we call those classified as department heads) now hire staff, prepare budgets and annual objectives, control expenditures, etc. They are becoming functional managers instead of the "pseudo-managers" that exist in most hospitals. This creates a much more dynamic and effective organization. (6.4)
- Authority was decentralized in the Nursing Department. **Reason:** The philosophy of the head nurse was to increase problem solving at the unit level. (7.3)

b. Pharmacy

- A unit dose system was initiated in the pharmacy, involving substantial renovations, the establishment of satellite pharmacies, and the expansion of staff. (6.2)
- Two satellite pharmacies were developed in order to service the unit dose system in the Neonatal Intensive Care Unit and on major surgical and medical wards. **Reason:** To reduce inventory, to provide clinical pharmacy services, and to reduce medication errors. (6.7)

- A satellite pharmacy system was introduced. **Reason:** Drug costs were high and getting higher. Also, clinical pharmacists who have much to offer in patient care were unable to contribute much if relegated to a dispenser role in a central pharmacy. As a result of this innovation, costs are better controlled, enormous changes in prescribing habits are observed, and a dramatic decrease in medication errors has occurred. (8.3)

c. Library

- The library has been decentralized to each service, because budget cuts made centralized library services too costly. (9.8)

d. Continuing Education

- The Department of Continuing Education has been decentralized from the director of continuing education to clinical directors. **Reason:** Since the clinical directors are responsible for the educational needs of their sections, it is appropriate that they have the staff to provide this education. (3.29)

2.3.2 Non-Medical Functions

Finance

Internal audit work was removed from the control of the Budget Control Department and placed under the control of a new Internal Audit Department. **Reason:** Budget control and reporting have become more complex over the last five years. Continual changes are being made to enhance internal budget reporting. A decision was made that more time must be spent by this department on the budget and less time on other matters (7.3)

2.4 Creation of New Roles**

Like any other kind of organizational innovation, the creation of a new role may be seen as a response to a variety of environmental influences. Appearing below is a comprehensive list of all roles reported by survey respondents as innovations. Because so many of these roles apply to nurses, this group has been singled out. Although roles appearing in the second group may, in some cases, be filled by nurses, the word "nurse" does not appear in the role title.

** See Appendix II for a "List of Hospital Roles or Employee Groups Reported as Unionized by Union Representatives".

2.4.1 Nursing Roles

- . Assistant Director of Nursing (6.7)
- . Audit Nurse (2.1)
- . Clinical Development Nurse (2.1)
- . Clinical Instructor in ICU (Intensive Care Unit), CCU (Critical Care Unit), and PCU (Palliative Care Unit). (7.8)
- . Clinical Nurse Specialist* (4.2)
- . Clinical Nurse Specialist in Geriatrics (7.3)
- . Community Liaison Nurse/Psychiatry (3.29)
- . Coordinator of Nursing Care (10.1)
- . CVT Nurse Clinical (3.29)
- . Emergency Head Nurse Coordinator (9.7)
- . Fetal Assessment Nurse (3.29)
- . Hospital Intravenous Nurse (8.4)
- . Infection Control Nurse (8.3)
- . Nurse Educator (6.8)
- . Nurse Geriatric Specialist (6.4)
- . Nurse Specialist in Rehabilitative Medicine (6.4)
- . Nursing Planning Coordinator (3.29)
- . Oncology Liaison Nurse (8.3)
- . Oncology Teaching Nurse (7.3)
- . Oncology Room Head Nurse Coordinator (9.7)
- . Pre-operative Teaching Nurse (8.3)
- . Psychogeriatric Nurse (6.4)
- . Quality Assurance Nurse (2.5; 4.9)

2.4.2 Other Roles

- . Administrative Projects Officer (4.2)

- . Assistant Executive Director, Medical Affairs (5.7)
- . Budget Control Clerk (6.8)
- . Chief of Physical Rehabilitation (9.7)
- . Computer Consultant (6.8)
- . Consultant in Administrative Procedures (9.5)
- . Coordinator of Computer Services (4.7)
- . Coordinator of Volunteers (3.1)
- . Director of Community and Professional Services (3.9)
- . Director of Labour-Management Relations* (1)
- . Director of Pastoral Services (1.2)
- . Director of Technical Resources (4.7)
- . Director of Vocational Services (3.9)
- . Director of Volunteer Services (1.3)
- . Discharge Planner (6.8)
- . Discharge Planning Officer (7.1)
- . Emergency Room Physician (7.1)
- . Infection Control Practitioner (6.8)
- . Manager of Staff Development* (1)
- . Medical Director of Chronic Unit (4.1)
- . Palliative Care Coordinator (6.0)
- . Patient Ombudsman (8.3)
- . Patient Representative (6.7)
- . Public Relations Director (5.3)
- . Quality Assurance Coordinator (5.8; 6.6; 6.7)
- . Unit Coordinator (2.7)
- . Unit Director (3.9)

2.5 Changes in Scheduling

Establishing new "time boundaries"--by changing department hours, staff working hours, or visiting hours - is yet another way hospitals try to adapt to external changes and requirements. Examples are shown below:

- Physicians are now scheduled for the afternoons in the Emergency Department. **Reason:** Physicians and surgeons had been asking their patients to report to the Emergency Department at random times. The patients often arrived in the mornings, when their doctors were frequently tied up in the operating room or on rounds. This created an unnecessary bottleneck in the Emergency Department and produced poor in public relations (4.5)
- The hours of the Physiotherapy Outpatient Department have increased from part-time to full-time: 7:30 a.m. to 4:30 p.m. **Reason:** There is an increasing demand for outpatient therapy (6.8)
- The Medical Records Department offers a 24-hour service all year round. Previously, weekends and evening and night hours were not covered. **Reason:** The Admitting Department had previously pulled charts out on weekend hours. Unfortunately, the number of charts requested by the Emergency Department increased, and the Admitting Department could no longer cope with the excessive number of requests (4.8)
- The home care nurse has increased her hours on duty in the hospital. **Reason:** There is an increasing number of referrals to home care, and the volume of work necessitated the increase in time (6.8)
- The laboratory technicians' hours of work were increased. **Reason:** The volume of work generated since the doctors were assigned to a particular floor necessitated an increase. At times the doctors have to be questioned about the amount of lab work ordered (6.8)
- Work schedules have been reviewed throughout the organization and have been changed (extended, etc.) in several areas. **Reason:** To improve service and reduce costs (6.1)
- Visiting hours were changed to accommodate workers who had changed to 12-hour shifts (5.3)
- Hours were extended to satisfy patients and visitors (8.7)

- . Afternoon visiting hours were eliminated on obstetrical units to allow mothers more rest as well as more time with their babies, and to allow nurses more teaching time with the mothers. Visitors were permitted between 7:00 p.m. and 8:00 p.m. (3.29)

2.6 Vertical Integration vs. Contracting Out

"Vertical integration" is the extension and subsequent incorporation of successive stages of the process by means of which goods and/or services are produced or provided. An example of this in hospitals is the opening of a printing shop within the hospital in order to produce more economically the necessary forms used in patients' records, etc.

"Contracting out", on the other hand, means that the organization elects to obtain goods and/or services from external suppliers rather than to produce them inside the organization.

Decisions concerning the cost efficiency and effectiveness of vertical integration vs. contracting out will depend upon the individual circumstances of each hospital. Examples of each of these two kinds of innovations appear below.

2.6.1 Vertical Integration

- . A print shop was opened. (2.2; 5.3)
- . More laundry is now being done in-house. (6.8)
- . Contracted food services were eliminated. (5.3)
- . There was a conversion of all financial systems from services purchased from a central bureau to an in-house computer. (5.7)

2.6.2 Contracting Out

- . We contracted management of food services. (3.8; 5.4)
- . On the retirement of employees in the housekeeping staff, some functions have been taken over by a contract service. (6.8)
- . We have contracted housekeeping management. (1.8; 4.4)
- . The expertise of an outside agency was purchased to direct and coordinate plant operations, maintenance and engineering. (4.7)
- . Payroll was sent to an outside computer firm. (6.8)

2.7 Phasing Out

Mainly in response to the need to improve cost efficiency in the face of severe budget cuts, a number of hospitals have reported the phasing out of a variety of departments, programs, services, functions or roles.

2.7.1 Phased Out Functions

The implanting of permanent pacemakers was phased out. Because of cost containment, this program could no longer be funded. (4.5)

2.7.2 Phased Out Clinics, Departments, Programs, Services, etc.

- . Obstetrical services were phased out. (1.4)
- . This hospital is reducing to zero its responsibility for funding the Mental Hygiene Institute, in order to meet budget requirements. (8.4)
- . We will phase out our nursing assistant school because of lack of employment prospects for nursing assistants and because of lack of funds. (7.9)
- . We have phased out staff education to reduce costs (1.8)
- . We have phased out a sexual therapy service to save money. (1.2)
- . The acute care medical and surgical nursing units and the entire obstetrical services unit were closed because of insufficient budget. (8.4)
- . Audiology services were phased out as a result of recent budgetary cutbacks. (8.5)

2.7.3 Phased Out Roles

- . The position of a Registered Nurse dedicated to the Pain Centre, whose function was to serve as a consultant to nursing staff throughout the hospital, was phased out because of budget cuts. (8.4)
- . Medical and nursing tasks were redivided, causing displacement of several Operating Room technical assistants. (9.5)
- . The medical staff has been completely re-organized and by-laws rewritten; and the number of doctors on staff reduced from 600 to 165. This followed recommendations made by Accreditation and the hospital role study. (6.8)
- . Head nurse role was phased out. (6.7)

- Patient care coordinator role was phased out. (6.7)
- The pre-operative teaching nurse position was phased out because of insufficient budget. (8.4)
- Four administrative coordinator positions were deleted, and two assistant directors of nursing were appointed. The nursing office supervisor positions were deleted and replaced by staffing clerks. (6.7)
- Seven supervising orderlies were phased out. The positions were redundant, and the functions were carried out by the head nurse managerial role. (7.3)
- Chiefs of Physical and Occupational Therapy departments were replaced by one chief of Physical Rehabilitation. (9.7)
- The position of chief residential counsellor was phased out. (3.9)
- The role of communications manager was phased out at the conclusion of a special project. (4.7)
- The position of purchasing manager was phased out. (8.4)

3. INTER-ORGANIZATIONAL INNOVATIONS

Inter-organizational innovations are those that entail the involvement of one or more health care institutions in the vicinity. These innovations represent an attempt to share certain support services, usually for reasons of cost efficiency. Such support services are grouped below as (a) Medical Support Services, (b) Non-Medical Support Services and (c) Mixed.

3.1 Medical Support Services

- Hospitals and community pharmacies pay annually to an independent committee which operates a drug information service to the members. The service is operated from within the Drug Information Centre of our hospital. (4.8)
- The pharmacy departments of two hospitals are cooperating in the following way: the silver sulfadiazine cream requirements of both hospitals will be met by one hospital, while nitroglycerine injection requirements will be met by the other. (4.8)
- Contracts have been drawn up between this hospital and nursing homes, as well as with a drug rehabilitation centre.
Reason: To take over the pharmacological services in auxiliary establishments. (8.7)

- Health care organizations in the region get together to discuss their common problems concerning sharing of services, such as pharmacy, computers, and consulting. **Reason:** The need for cost effectiveness. (9.8)

- Pharmaceutical services are supplied to neighbouring nursing homes, three pharmacist days were added to serve 200 residents in four centres. Medication is dispensed, and monthly visits and telephone services are provided. (9.8)

- Pharmacy service contracts between our hospital's pharmacy and neighbouring institutions have been drawn up in order to maintain high scientific quality. (10.2)

- Regional services are provided to small hospitals and/or clinics within the region by the following personnel:

Audiologist
Speech pathologist
Psychologist
Dietitian
Physiotherapist
Laboratory director
Chief X-ray technologist

Reason: To ensure that as many people as possible would receive services available in the hospital. Needs were identified from the Central Region, and action taken in an attempt to meet those needs through visiting clinics, reaching out, etc. (8.0)

- In order to increase the range of expertise within a hospital department, the Biomedical Department sells services to regional hospitals. Revenue generated is used to hire additional expertise, or to duplicate existing expertise for long-term stability of service. **Reason:** A wide range of medical equipment requires diverse expertise to maintain and manage. Such expertise is scarce and expensive to recruit. Support from different hospitals makes possible the building of a strong expert group which can be maximally utilized. (4.8)

- An education program has been developed in conjunction with the local board of education. **Reason:** Lack of educational opportunity for our eight profoundly handicapped children. (3.9)

- A regional admission committee to long-term and chronic care hospitals was established to plan in an orderly manner all admissions of elderly people to all the establishments in our region. (10.0)

- An admissions committee was created in long-term care and nursing home centres to centralize admissions. (8.9)

3.2 Non-Medical Support Services

- Computer services are dispensed on a regional basis, meeting the accounting and payroll needs of four nursing homes. (9.8)
- Materials management services were amalgamated with a neighbouring hospital. **Reason:** Both hospitals were financially strained. Sharing a service with a neighbouring hospital will permit us to reduce costs. (6.3)
- Laundry was closed, and we now participate in a centralized laundry. **Reason:** Space was required for new construction. (1.8)
- We expanded our laundry services to serve a small local hospital and a local university residence. (5.3)

3.3 Mixed

Directors of departments are being shared with other institutions; e.g., director of personnel, director of microbiology and director of urology. (8.35)



SECTION THREE



THE NECESSARY CONNECTION BETWEEN EMPLOYEE SATISFACTION AND THE PROVISION OF QUALITY HOSPITAL SERVICE

Hospitals across the country have indicated their awareness of the importance of employee satisfaction in the delivery of high quality hospital services by including in their innovations a number of new policies or programs that focus on staff problems or staff needs. These include:

1. MANAGEMENT INCENTIVE PROGRAMS

- . Staff Development Program (3.2)
- . Human Resources Development (4.1)
- . Effective Management Workshop (6.8)
- . Management Information Manual. This manual contains a variety of regularly supplemented articles concerning management, organizational change, communication, etc. Selected managers then lead discussion groups on particular articles. (3.9)

2. EMPLOYEE INCENTIVE PROGRAMS

- . Day Care for Employees' Children (9.6; 10.3)
- . Employee Recognition Program (7.0; 1)
- . Employee Recreation Committee (9.9)
- . Employee Fitness Program (4.1)
- . Attendance Incentive Program: a system of reviewing incentives to reduce absenteeism (3.9)
- . Support System: to help staff deal with terminal illness (6.7)
- . Weekly Meetings with Medical Technologists: to reduce work-related stress (4.8)
- . Disuse of Punchcard System: to improve the working environment (10.0)
- . Interprofessional Committee (9.9)

3. EMPLOYEE ASSISTANCE PROGRAMS

- . Employee Assistance Programs (3.0; 3.2; 3.3; 5.1; 6.5; 7.0; 7.9; 8.0)
- . Joint Management-Union Employee Assistance Program* (5.4)

4. SAFETY PROGRAMS

- . Fire Safety Committee (6.8)
- . Health and Safety Committee (1.9; 4.9; 5.3; 5.7; 8.35; 9.9; 13)
- . Safety Committee (5.3)

5. PLANNED SOCIAL EVENTS, CEREMONIES, ETC.

- . Annual Picnic (I)
- . Birthday Cards and one free meal for employees' birthdays (I)
- . Employee of the Month Award (I)
- . Free Coffee and Donuts After 30 days of safe (no injury) operation (I)
- . Retirement Teas (I)

6. THE CREATION OF A SPECIAL ROLE

- . Administrative Projects Officer:

The Administrative Projects Office is responsible for developing, implementing, and monitoring attendance awareness, occupational health and safety, workers' compensation, and the Employee Assistance Program. The incumbent identifies abuses (e.g., absenteeism), recommends disciplinary or corrective action, counsels staff and identifies problem areas concerned with safety. He or she fulfills a special project function by investigating complaints from the public regarding treatment procedures and patient care. If necessary, he or she recommends procedural or policy changes. Presenting workshops on attendance awareness and occupational health and safety in conjunction with the Personnel Department and Educational Services is one of the liaison functions of this position.

This role was created in response to the need to coordinate the responsibilities of the Attendance Improvement Program, the Occupational Health and Safety Program, the Rehabilitation Program, and the Employee Assistance Program. The Attendance Improvement Program has reduced absenteeism by 20% to 25% during the three years of its operation. During the first year of the Occupational Health and Safety Program, there was a reduction in incidents and in time lost due to accidents by 1,000 days. Also, the severity of injuries is less than before the program. Statistics on referrals to the Employee Assistance Program are not kept, to ensure confidentiality (4.2).

7. CHANGES IN SCHEDULING

Most of the innovations reported in this area involved an extension of the traditional 8-hour shift to a 12-hour shift, primarily among the nursing staff, especially those working in areas such as ICU, CCU, and the Emergency Department. The reasons given for this type of change included: (1) collective agreements, (2) the desire to reduce absenteeism and turnover, and (3) the desire to improve recruitment. These changes were reported to have improved morale in some cases, and to have helped reduce absenteeism in other cases.

Other innovations involving scheduling have been treated earlier in the report (see Section Two: 2.5). However, because the following examples seem to have been motivated more by staff demands than by specific scheduling requirements of the hospital itself, they have been included in this section:

- . The change from 8-hour to 12-hour shifts for nurses (1.0; 2.4; 3.1; 4.5; 4.6; 4.7; 4.8; 5.3; 7.1; 8.4)
- . The change from 8-hour to 12-hour shifts in the Respiratory Department (2.4)
- . The change from 8-hour to 12-hour shifts for power plant operators (7.3)
- . Seven days of work and seven days off (9.7) (employee group unspecified)
- . Reduction of workweek from 40 hours to 37½ hours (3.8) (employee group unspecified)



SECTION FOUR

INNOVATIONS THAT REFLECT QUALITY OF WORKING LIFE VALUES

Quality of working life is the name applied to approaches and methods aimed at the improvement of organizations, whether in the private or the public sector. The objectives of this approach are to upgrade organizational effectiveness and, at the same time, increase worker satisfaction. The effect of this approach is to strengthen people's commitment to the goals of the organization to which they belong. Such commitment, in the case of hospitals, would increase the probability that the kind of health care provided will be quality assured with respect to both technological and interpersonal skills, as well as integrated at the level of patient care; that it will "fit" the specific problems and needs of the community, as well as fulfill, to the extent possible, contemporary expectations and standards of excellence.

Although no Canadian hospital currently has in place a comprehensive quality of working life program, a number of survey respondents cited examples of innovations that reflect certain quality of working life principles and values. These include: (1) union-management collaboration; (2) role enrichment, cross-training and multi-skilling; and, (3) multi-disciplinary and multi-level activities.

1. UNION-MANAGEMENT COLLABORATION

Union-management collaboration is a crucial ingredient in helping hospitals achieve a healthy balance between fulfilling their mandate to provide high quality patient care, and accomodating the needs, capacities, and values of those who have been hired to help carry out this mandate, whether professionals or non-professionals. Innovations include the following:

- . Joint union-management meetings are regularly scheduled. (1.1; 1.9; 3.7; 4.9; 7.0; 7.4; 9.05; 19)
- . New employees are met by the union representative at orientation. (1)
- . A union observer is present at selection panel. (1.1)
- . A labour-management committee was formed. (7.8)
- . A Joint Management-Union Employee Assistance Program was formed. Both groups recognized that the only avenue for staff to seek confidential help with personal problems was through mandatory referrals emanating from fact-finding meetings. The goal was to reduce disciplinary action and improve productivity by facilitating staff help through a non-threatening program. (5.4)

2. ROLE ENRICHMENT, CROSS-TRAINING AND MULTI-SKILLING

Organizational literature tends to confirm that job satisfaction is closely linked with the presence of certain types of job characteristics. These characteristics include: (1) variety of tasks, (2) the opportunity to have an input into decision making about how one's work is to be done, (3) the opportunity to learn and develop, (4) the opportunity to advance in the organization, and (5) the respect and support of one's co-workers. Role enrichment, cross-training, and multi-skilling are attempts to build some of these job characteristics into organizational roles. Innovations in these three areas appear below.

2.1 Role Enrichment

- a. The medical director's role was enlarged and hours increased. Reservations and Admitting (as well as the medical staff) now report to the medical director. (6.8)
- b. Primary nursing care was introduced. **Reason:** There had been a growing concern among health care professionals about the fragmentation of care when using the team-nursing approach, and the need for more consistent patterns of care was recognized. Also, primary care nursing enhances job satisfaction. (8.3)
- c. The head nurse's role was redefined as "patient care coordinator". She now assumes "on call" duty for evenings, nights, and weekends. (6.7)
- d. The role of the public health nurses has been expanded so that they are in the hospital for some part of most week days. **Reason:** This is a more efficient way of handling referrals to public health nurses and as a result is more beneficial to the patient. The frustration of many phone calls made by various staff members prompted this change. (6.8)
- e. The role of clinical nurse specialist was developed. This individual is responsible for upgrading the quality of nursing care by instructing nursing staff in direct patient care. Role modelling is used to demonstrate interviewing techniques, what to do in specific situations, etc. Consultations are requested by nursing staff and physicians. The clinical nurse specialist also carries a patient case load and instructs groups. The incumbent has an M.A., has published papers and conducted clinical psychiatric nursing research. The clinical nurse specialist has made an auditable difference in the quality of patient care. The success is such that the major objective of the nursing department is to increase the number of clinical nurse specialists serving the hospital. (4.2)
- f. The role of the occupational therapist in Day Hospital was changed to include consultative and group-oriented treatment activities. **Reason:** To have occupational therapy blend better with the overall goals of the Day Hospital. (4.8)

- g. The role of the Social Work Department has been changed from discharge planning only, to include counselling and participation in outside committees, as well as various program in the hospital. The staff has been increased to three social workers with degrees, plus the director. (6.8)
- h. The role of the pharmacists has changed. Where we previously had a nurse dispensing medications, we now have a full-time pharmacist, two part-time pharmacists and one full-time technician. Also, medication for the patients on a weekend pass is prepared in pharmacy instead of by the nursing staff. (6.8)
- i. Management's responsibilities have been expanded to include disciplinary action, layoffs, control of absenteeism, etc. **Reason:** To increase the autonomy of managers. (10.4)

2.2 Cross-Training and Multi-Skilling

Cross-training and multi-skilling are closely related. In fact, cross-training may be described as the method by means of which multi-skilling occurs. For example, a decision may be made within a laboratory that all technicians should be cross-trained in order to become adept at carrying out one another's routine procedures. If, to start, there are ten specialists in the group, then at the end of the cross-training, each technician will have acquired nine additional skills, and will be in a position to alternate tasks with any of the others.

The alternation of tasks made possible through multi-skilling has a number of advantages for both the individual worker and the department: (1) it increases the amount of variety and learning in each employee's work, and thus helps to enhance job satisfaction; (2) it permits each employee to become familiar with the specific activities required for each job, which results in an eventual improvement in the integration of all tasks required to carry out the department's objectives; (3) it encourages each employee to learn the "language" specific to each job, so that there will be a gradual improvement in understanding and communication between employees, and (4) it helps increase departmental flexibility, because any employee will be able to fill in for any other employee without any appreciable decrease in the quality of the task performed.

Reported innovations that reflect cross-training or multi-skilling (or both) are indicated below:

- a. We have trained all our staff in Radiology to perform CT scans. **Reason:** To reduce the overtime hours required to perform emergency CT scans. Previously, after 4:30 p.m. these scans were covered on an on-call basis. This proved very costly, not to mention inconvenient to the patients who needed to wait, and the technologist who had to come in. Now, whenever a scan is required, it is done immediately with no delays. This system has not only increased our ability to serve, but has enabled us to reduce our expenses by some \$20,000 per year. (4.8)

- b. The part-time linen room worker increased her hours to full-time, and her duties were also increased to assist in the laundry. **Reason:** With more patients in the hospital each year, the amount of work in the laundry has increased. In order to have the laundry follow some suggestions for controlling the linen, an extra staff member was requested for certain periods of the day. It was felt the best way was to increase the hours of the linen room worker and have her assist when necessary in the laundry. (6.8)
- c. Medical nursing procedures* have been identified. Functions normally considered medical practice, which can be carried out by the nurse with special preparation, are listed below in alphabetical order. These functions may be performed only within written agency policy, and upon the written order of a physician, by the nurse with special preparation.
- . Arterial puncture
 - . Removal of biliary T-tubes
 - . Removal of central venous pressure lines
 - . Delivery of infants
 - . Episiotomies
 - . Intradermal injections
 - . Intravenous therapy
 - . Administration of intravenous medication
 - . Suturing of minor lacerations
 - . Syringing of the aural canal
 - . Tonography and tonometry
 - . Changing of the outer canula of a tracheotomy tube
 - . Vaginal examination
 - . Venipuncture to withdraw blood from arm or scalp vein

* Please note that the original data from which the above list was obtained contained a detailed account of the special circumstances under which these procedures may be carried out by a nurse.

- d. The motor service was reviewed and, in order to provide back-up time for illness, we hired an extra person for the department. This person can also relieve in housekeeping, general stores, maintenance, laundry, and with portering. **Reason:** There was a need for someone on staff who could be moved quickly from one department to another for relief work. (6.8)
- e. There was fusion of the Accounting and Collection Departments. **Reason:** To allow employees to perform multiple tasks. (9.9)

3. MULTIDISCIPLINARY AND MULTI-LEVEL ACTIVITIES

Multidisciplinary and multi-level activities include all meetings, committee formations, etc., in which people representing disparate functions and levels of the hospital get together to make policy, identify or solve problems, clarify goals, make decisions, or resolve conflicts. Just as multi-skilling, at the departmental level, helps to integrate the different tasks required to achieve departmental objectives, the creation of multidisciplinary and multi-level organizational structures helps to integrate the highly differentiated functions required to achieve hospital objectives, particularly those which pertain to patient care. Without such structures, hospital objectives become increasingly diffuse and scattered, and people begin working at cross-purposes, with little or no sense of how their tasks relate to the goals of the organization as a whole. Innovations in this category are listed below:

- a. There has been a gradual move from the traditional medical model to that of a multidisciplinary team. (6.5)
- b. A medical/nursing liaison was formed. It was felt desirable to have further formalized meetings between medical and nursing staffs to more readily resolve problems. (1)
- c. A multidisciplinary team was created to integrate doctors, nurses and laboratory personnel in order to reduce costs and increase communication. (8.6)
- d. The medical staff committees--Admission and Discharge, Health Records, Clinical Laboratories, and Pharmacy and Therapeutics--became more active and now meet regularly. (6.8)
- e. The medical staff committees--Medical Audit, Radiology, Credentials, Rules and Regulations, and Infection Control--were formed and meet regularly. (6.8)
- f. An Audiology and Speech Committee was formed, with representatives from Otolaryngology, Audiology, Speech, General Medicine, and Administration. This was done to facilitate policy development, improve coordination of services, and assist communication. (8.35)

- g. A Medication System Study Group was formed to review the present medication system and to make recommendations so as to ultimately improve patient care. This committee has representation from the medical staff, pharmacy, nursing and administration. (8.35)
- h. A Cybernetics Committee was formed to develop policies and make recommendations with the goal of improving efficiency, cost effectiveness, and quality of services through the application of technology. It has representation from the medical staff, the non-medical professional staff, the research institute, diagnostic services, and administration. (8.35)
- i. A Child Protection Committee made up of a multidisciplinary team was formed in response to the introduction of new child protection laws. (8.35)
- j. A "Hope and Cope" outreach program for cancer patients was developed. The hospital had developed a large Oncology Centre, and was using innovative forms of therapy and chemotherapy for an outpatient population. Many patients had difficulty in coping with their cancer, and were demoralized at the extensive and extremely uncomfortable treatments. It was felt that a multidisciplinary outreach group, including volunteers who themselves had been cured of cancer, would provide emotional support and encourage self-management and self-esteem. (8.3)
- k. A multidisciplinary committee was formed to provide a support service for patients and relatives involved with a potentially terminal illness, as well as a staff educational and support system for dealing with the terminally ill. (6.7)
- l. A multidisciplinary "stroke team" was developed to provide a coordinated approach to the management of stroke victims, and to provide teaching and support for their families. This was done because the number of stroke victims entering the hospital was steadily growing, and it was felt that their care could be improved. Of special importance to us was the victim's family who were often deeply concerned, especially at the thought of having to care for a relative at home. This program was an outstanding success. (8.3)
- m. A Progressive Cardiac Care Unit and Cardiac Rehabilitation Team were developed, using a multidisciplinary approach. This was done because at least some post-myocardial infarct patients become either physical or psychological "cardiac cripples", unnecessarily. (8.3)
- n. An interdisciplinary educational program was formed for patients with chronic obstructive lung disease. This eight-week outpatient program was offered on a continued basis for patients who suffer from chronic pulmonary problems and for their spouses. The evaluation of the programs indicated a significant reduction in the number of hospitalization days, as well as an improvement in the quality of the clients' lives. (4.7)

- o. An interdisciplinary Geriatric Care Team was formed, consisting of a doctor, a nurse, a physiotherapist, volunteers, and other professionals (as required). (8.5)
- p. An interdisciplinary team was formed, headed by a chief internist/geriatrician, and including other geriatricians, a psycho-geriatrician, a nurse consultant, a social worker, an occupational therapist, a recreational therapist, a physiotherapist, volunteers and a secretary. The members of this team function as a mobile consultative resource. (8.2)
- q. A Palliative Care Consultative Service was developed by a team consisting of two nurses and a group of volunteers who administer to the special needs of dying patients. This service was created in response to a seeming lack of concern for the special needs of the dying. (4.9)
- r. A Palliative Care Team was created, consisting of a nurse, a social worker, a pastoral care worker, plus a $\frac{1}{2}$ physician. This team assists dying patients and their relatives, and also educates and assists the staff and physicians. This team was created as a consequence of a research study which outlined the needs of dying patients, their relatives, and staff. (4.3)
- s. Multidisciplinary committees were created in order to assess newly admitted patients and those having functional rehabilitative possibilities. (10.1)
- t. A new performance appraisal program was developed. New forms, policy, and procedures allow for more employee input, and greater emphasis is placed on establishing guidelines for future developments. (3.2)
- u. An interdisciplinary Family Planning Clinic was established. This clinic, which is run by a team of four gynecologists, one nurse, and one social worker, deals with such issues as sex education, sterilization, infertility, and therapeutic abortion. (10.0)
- v. A Patient Care Assessment Committee (Quality Assurance), which is a committee of the Clinical Staff Advisory Council, was formed to facilitate problem solving, to improve communication between disciplines, to improve documentation, to reinforce quality assurance practices and to meet accreditation guidelines. (8.35)
- w. An Administration Service Audit Committee was formed. Its purpose is to conduct and review regular audits of direct and/or indirect patient care for the departments of Clinical Dietetics, Occupational Therapy, Pharmacy, Physiotherapy, Laboratory Medicine, Radiology, and Respiratory Technology. Each department, through the audit, selects a topic to document and review, develops criteria, reviews the charts, analyzes variations, identifies problems, and develops, implements and evaluates

remedial action. The complete process is reviewed by the Audit Committee, and is reported to the associate executive director. This committee was formed because of a lack of audit procedures for many administration services, and a desire to document certain patient care activities to ensure high quality care. (7.0)

- x. A quality assurance discharge planning officer is being hired. We felt that, in a small hospital such as ours, the functions of quality assurance and discharge planning could be combined. This person will allow us to carry out a multidisciplinary quality assurance program, and coordinate discharge planning, social services, and nursing. We feel that quality assurance monitoring should be an interdisciplinary process in the hospital in order to ensure that total patient care is being provided to patients. Reason: With constraints on hospital resources and a high occupancy rate in the hospital, the discharge of patients was a more formal process than it had been in the past, and it had to be planned when the patient was admitted to the hospital. The coordination of discharge planning under one person would ensure that all avenues of patient placement (after active hospital treatment was no longer required) were reviewed and utilized. This could not be done without a person coordinating the entire process. (2.4)

APPENDICES



APPENDIX I

ADDRESSES OF HOSPITALS FROM WHICH INNOVATIONS WERE REPORTED

- | | |
|--|--|
| <p>1.0 Executive Director
Royal Inland Hospital (G)
311 Columbia Street
Kamloops, B.C.
V2V 2T1 (604) 374-5111</p> | <p>1.7 Administrator
Trail Regional Hospital (G)
1200 Hospital Bench
Trail, B.C.
V6H 3O4</p> |
| <p>1.1 Institutional Manager
Tranquille Institution (MR)
P.O. Box 6000
Kamloops, B.C.
V2C 6C4 (604) 376-3361</p> | <p>1.8 Vice President, Administrator
Saint Paul's Hospital (G)
1081 Burrard Street
Vancouver, B.C.
V6Z 1Y6 (604) 682-2344</p> |
| <p>1.2 Executive Director
Kelowna General Hospital (G)
2268 Pandosy Street
Kelowna, B.C.
V1Y 1T2 (604) 762-4000</p> | <p>1.9 Administrator
Saint Vincent's Hospital (G)
749 West 33rd Avenue
Vancouver, B.C.
V5Z 2K4 (604) 877-7171</p> |
| <p>1.3 Executive Director
Royal Columbian Hospital (G)
330 East Columbia Street
New Westminster, B.C.
V3L 3W7 (604) 520-4253</p> | <p>2.0 Administrator
Glendale Lodge (MR)
P.O. Box 4250, Station A
Victoria, B.C.
V8X 3X9 (604) 479-7101</p> |
| <p>1.4 Assistant Executive Director
Saint Mary's Hospital (G)
220 Royal Avenue
New Westminster, B.C.
V3L 1H6 (604) 521 1881</p> | <p>2.1 Executive Director
Colonel Belcher Hospital (G)
1213-4th Street S.W.
Calgary, Alberta
T2V 0X7 (403) 264-1850</p> |
| <p>1.5 Senior Assistant Administrator
Lions Gate Hospital (G)
15th Street and Saint Georges
North Vancouver, B.C.
V7L 2L7 (604) 988-3131</p> | <p>2.2 Administrator
Charles Camshell General
Hospital (G)
12815-115 Avenue
Edmonton, Alberta
T5M 3A4 (403) 453-5311</p> |
| <p>1.6 Administrator
Saanich Peninsula Hospital (G)
2166 Mount Newton Crossroad
Box 10
Saanichton, B.C.
V0S 1M0 (604) 652-3911</p> | <p>2.3 Unit Administrator
Grandview Extended Care
Centre (LT)
6215-124 Street
Edmonton, Alberta
T6H 4P4 (403) 436-4130</p> |

G = General; LT = Long Term; MR = Mental Retardation Facility;
P = Psychiatric.

- | | |
|--|--|
| <p>2.4 Assistant Administrator
St. Michael's General
Hospital (G)
1315-9th Avenue South
Lethbridge, Alberta
T1J 1X7 (403) 327-1531</p> <p>2.5 Assistant Executive Director
Medicine Hat and District
Hospital (G)
666-5th Street S.W.
Medicine Hat, Alberta
T1A 4H6 (403) 527-2211</p> <p>2.6 Manager
Research, Planning and
Evaluation
Alberta Hospital (P)
P.O. Box 1000
Ponoka, Alberta
T0C 2H0 (403) 783-3351</p> <p>2.7 Executive Director
Red Deer Regional Hospital (G)
3942-50A Avenue
Red Deer, Alberta
T4N 4E7 (403) 343-4600</p> <p>2.8 Executive Director
Moose Jaw Union Hospital (G)
455 Fairford Street East
Moose Jaw, Saskatchewan
S6H 1H3 (306) 692-1841</p> <p>2.9 Executive Director
Holy Family Hospital (G)
675-15th Street West
Prince Albert, Saskatchewan
S6V 3R8 (306) 922-2605</p> <p>3.0 Administrator
Pasqua Hospital (G)
4101 Dewdney Avenue
Regina, Saskatchewan
S6V 5T4 (306) 359-2363</p> | <p>3.1 Administrator
Plains Health Centre (G)
4500 Wascana Parkway
Regina, Saskatchewan
S4S 5W9 (306) 584-6208</p> <p>3.2 Executive Assistant
Regina General Hospital (G)
1440-14th Avenue
Regina, Saskatchewan
S4P 0W5 (306) 359-4259</p> <p>3.29 President
Saint Boniface General
Hospital (G)
409 Tache Avenue
Winnipeg, Manitoba
R2H 2A6 (204) 233-8563</p> <p>3.3 Associate Executive Director
Victoria General Hospital (G)
2340 Pembina Highway
Winnipeg, Manitoba
R3T 2E8 (204) 477-3379</p> <p>3.4 Administrator
Adult Occupational Centre (MR)
P.O. Box 12000
Barrie, Ontario
L4N 1G4 (705) 728-6910</p> <p>3.5 Chief Executive Officer
Royal Victoria Hospital (G)
76 Ross Street
Barrie, Ontario
L4N 1G4 (705) 728-9802</p> <p>3.6 Administrator
Peel Memorial Hospital
20 Lynch Street
Brampton, Ontario
L6W 2Z8 (416) 451-1710</p> |
|--|--|

G = General; LT = Long Term; MR = Mental Retardation Facility;
P = Psychiatric.

- | | |
|---|--|
| <p>3.7 Administrator
Brockville General Hospital (G)
75 Emma Street
Brockville, Ontario
K6V 1S1 (613) 345-5645</p> <p>3.8 Assistant Administrator
Public General Hospital (G)
106 Emma Street
Chatham, Ontario
N7L 1A8 (519) 352-6400</p> <p>3.9 Administrator
D'Arcy Place Development
Centre (MR)
700 D'Arcy Street
Cobourg, Ontario
K9A 4L5 (416) 372-3341</p> <p>4.0 Assistant Executive Director
Queensway General Hospital (G)
150 Sherway Drive
Etobicoke, Ontario
M9C 1A5 (416) 259-6671</p> <p>4.1 Executive Director
Saint Joseph's Hospital (G)
80 Westmount Road
Guelph, Ontario
N1H 5H6 (519) 824-2620</p> <p>4.2 Executive Director
Hamilton Psychiatric
Hospital (P)
100 West 5th Street
Box 585
Hamilton, Ontario
L8L 2X2 (416) 388-2511</p> <p>4.3 Assistant Executive Director
Saint Joseph's Hospital (G)
50 Charlton Avenue East
Hamilton, Ontario
L8N 1Y4 (416) 522-4941</p> | <p>4.4 Administrator
Leamington District
Memorial (G)
Talbot Street West
Leamington, Ontario
N8H 1N9 (519) 326-6131</p> <p>4.5 Assistant Administrator
General Services
Ross Memorial Hospital (G)
10 Angeline Street North
Lindsay, Ontario
K9V 4M8 (705) 324-6111</p> <p>4.6 Assistant Administrator
London Psychiatric Hospital (P)
P.O. Box 2532, Terminal "A"
London, Ontario
N6A 4H1 (519) 455-5110
Ext. 203</p> <p>4.7 Associate Executive Director
Saint Joseph's Hospital (G)
268 Grosvenor Street
London, Ontario
N6A 4V2 (519) 439-3271</p> <p>4.8 Management Consultants'
Professional Services
Ottawa General Hospital (G)
5901 Smyth Road
Ottawa, Ontario
K1H 8L6 (613) 737-7777</p> <p>4.9 Executive Director
Riverside Hospital of Ottawa (G)
1967 Riverside Drive
Ottawa, Ontario
K1H 7W9 (613) 731-6710</p> <p>5.0 Assistant Executive Director
Owen Sound General and Marine
Hospital (G)
1201-6th Avenue West
Owen Sound, Ontario
N4K 5H3 (519) 376-2121</p> |
|---|--|

G = General; LT = Long Term; MR = Mental Retardation Facility;
P = Psychiatric.

- | | |
|---|---|
| <p>5.1 Executive Director
Saint Joseph's General
Hospital (G)
384 Rogers Street
Peterborough, Ontario
K9H 7B6 (705) 743-4251</p> | <p>5.8 Executive Director
McKellar General Hospital (G)
325 South Archibald Street
Thunder Bay, Ontario
P7E 1G6 (807) 623-5561
Ext. 711</p> |
| <p>5.2 Associate Administrator
The Etobicoke General
Hospital (G)
101 Humber College Boulevard
Rexdale, Ontario
M9V 1R8 (416) 744-3466</p> | <p>5.9 Director
Northwestern Regional
Centre (MR)
580 North Algoma Street
Box 3270
Thunder Bay, Ontario
P7B 5J8</p> |
| <p>5.3 Assistant Executive Director
St. Catherines General
Hospital (G)
142 Queenston Street
Saint Catherines, Ontario
L2R 7C6 (416) 684-7271</p> | <p>6.0 Executive Director
Saint Joseph's General
Hospital (G)
35 North Algoma Street
Box 3251
Thunder Bay, Ontario
P7B 5G7 (807) 344-2431</p> |
| <p>5.4 Assistant Administrator
St. Thomas Psychiatric
Hospital (P)
P.O. Box 2004
St. Thomas, Ontario
N5P 3V9 (519) 631-8510
Ext. 310</p> | <p>6.1 Executive Director
Saint Mary's General
Hospital (G)
41 Pine Street North
Timmins, Ontario
P4N 6K7 (705) 267-2131</p> |
| <p>5.5 Administrator
Rideau Regional Centre (MR)
P.O. Box 2000
Smith Falls, Ontario
K7A 4T7 (613) 283-5533</p> | <p>6.2 Assistant Administrator,
Finance
The Hospital for Sick
Children (G)
555 University Avenue
Toronto, Ontario
M5G 1X8 (416) 598-5707</p> |
| <p>5.6 Assistant Administrator
Smith Falls Community
Hospital (G)
60 Cornella Street West
Smith Falls, Ontario
K7A 2H9 (613) 283-2330</p> | <p>6.3 Administrator
The Princess Margaret
Hospital (G)
500 Sherbourne Street
Toronto, Ontario
M4X 1K9 (416) 924-0671</p> |
| <p>5.7 Executive Director
Laurentian Hospital (G)
41 Ramsey Lake Road
Sudbury, Ontario
P3E 5J1 (705) 522-2200</p> | |

G = General; LT = Long Term; MR = Mental Retardation Facility;
P = Psychiatric.

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| <p>6.4 Executive Director
The Queen Elizabeth
Hospital (LT)
550 University Avenue
Toronto, Ontario
M5G 2A2 (416) 597-5003</p> <p>6.5 Assistant Administrator,
Paramedical
The Riverdale Hospital (LT)
14 Saint Matthews Road
Toronto, Ontario
M4M 2B5 (416) 461-8251
Ext. 2002</p> <p>6.6 Executive Director
The Wellesley Hospital (G)
160 Wellesley Street East
Toronto, Ontario
M4Y 1J3 (416) 966-6602</p> <p>6.7 Associate Executive Director
Women's College Hospital (G)
76 Greenville Street
Toronto, Ontario
M5S 1B2 (416) 966-7176</p> <p>6.8 Administrator
Saint John's Hospital (LT)
285 Cummer Avenue
Newtonbrook
Willowdale, Ontario
M2M 2G1 (416) 226-6780</p> <p>6.9 Associate Executive Director
Chaleur General Hospital (G)
1750 Sunset Drive
Box S
Bathurst, N.B.
E2A 4A4 (506) 548-8961</p> <p>7.0 Executive Director
Dr. Everett Chalmers
Hospital (G)
Priestman Street
Box 9000
Fredericton, N.B.
E3B 5N5 (506) 452-5400</p> | <p>7.1 Assistant Administrator
The Moncton Hospital (G)
135 MacBeth Avenue
Moncton, N.B.
E1C 6Z8 (506) 855-1600</p> <p>7.2 Administrator
Saint Joseph's Hospital (G)
130 Bayard Drive
Saint John, N.B.
E2L 3L6 (506) 652-2620</p> <p>7.3 Executive Director
Camp Hill Hospital (G)
1763 Robie Street
Halifax, N.S.
B3J 2H6 (902) 423-1371
Ext. 211</p> <p>7.4 Administrative Director
Victoria General Hospital (G)
1278 Tower Road
Halifax, N.S.
B3H 2Y9 (902) 428-2025</p> <p>7.5 Administrator
Saint Rita Hospital (G)
409, King's Road
Sydney, N.S.
B1P 2H8 (902) 539-3740</p> <p>7.6 Administrator
Colchester Hospital (G)
Willow Street
Truro, N.S.
B2N 5A1 (902) 895-5421</p> <p>7.7 Executive Director
Yarmouth Regional Hospital (G)
Vancouver Street
Yarmouth, N.S.
B5A 2P5 (902) 742-3541</p> |
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G = General; LT = Long Term; MR = Mental Retardation Facility;
P = Psychiatric.

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| <p>7.8 Executive Director
Queen Elizabeth Hospital
Inc. (G)
P.O. Box 6600
Charlottetown, P.E.I.
C1A 8T5 (902) 566-6111</p> <p>7.9 Assistant Administrator
Western Memorial Regional
Hospital (G)
West Valley Road
Box 2005
Corner Brook, Newfoundland
A2H 6J7 (709) 634-4393</p> <p>8.0 Administrative Assistant,
Outreach
Central Newfoundland
Hospital (G)
Union Street
Grand Falls, Newfoundland
A2A 2E1 (709) 489-5330</p> <p>8.1 Executive Director
Dr. Charles A. Janeway
Child Hospital Centre (G)
Newfoundland Drive
Saint John's, Newfoundland
A1A 1R8 (709) 778-4222</p> <p>8.2 Executive Director
Centre Hospitalier de
St. Mary (G)
3830 Lacombe Avenue
Montreal, Quebec
H3T 1M5 (514) 344-3197</p> <p>8.3 Director of Hospital Services
Jewish General Hospital (G)
3755 Cote Sainte-Catherine
Montreal, Quebec
H3T 1E2 (514) 342-3111</p> | <p>8.35 Director of Hospital Services
Montreal Children's
Hospital (G)
2300 Tupper Street
Montreal, Quebec
H3H 1P3 (514) 937-8511</p> <p>8.4 Director of Hospital Services
The Montreal General
Hospital (G)
1650 Cedar Avenue
Montreal, Quebec
H3G 1A4 (514) 937-6011</p> <p>8.5 Director of Hospital Services
The Queen Elizabeth
Hospital (G)
2100 Marlowe Avenue
Montreal, Quebec
H4A 3L6 (514) 488-2311</p> <p>8.6 Director of Hospital Services
Hotel-Dieu d'Alma (G)
300 Champlain Boulevard S.
Alma, Quebec
G8B 5W3 (418) 662-3421</p> <p>8.7 Directeur général adjoint
(D.S.H.)
Hotel-Dieu d'Arthabaska (G)
5, rue Quesnel
Arthabaska (Québec)
G6P 6N2 (819) 357-2031</p> <p>8.8 Directeur des communications
Hôpital de Chicoutimi (G)
305, rue Saint-Vallier
C.P. 5006
Chicoutimi (Québec)
J2C 4G6 (418) 549-2195
poste 246</p> <p>8.9 Directeur général
Centre Hospitalier de
Granby (G)
205, boulevard Leclerc
Granby (Québec)
J2G 1T7 (514) 372-5491</p> |
|---|--|

G = General; LT = Long Term; MR = Mental Retardation Facility;
P = Psychiatric.

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|---|---|
| <p>9.0 Directeur général
Centre Hospitalier
Jonquière (G)
450, rue de l'Hôpital
C.P. 1200
Jonquière (Québec)
J7X 7X2 (418) 547-3651</p> | <p>9.7 Directeur des services
hospitaliers
Hôpital Saint-Joseph de
Rimouski (G)
150, avenue Rouleau
Rimouski (Québec)
G5L 5T1 (418) 723-7851</p> |
| <p>9.1 Directeur général
Hôpital la Providence de
Magog (G)
50 est, rue Saint-Patrice
Magog (Québec)
J1X 3X3 (819) 843-3381</p> | <p>9.8 Directeur
Services auxiliaires et
hospitaliers
Centre Hospitalier
Laurentien (G)
234, rue Saint-Vincent
Ste-Agathe des Monts (Québec)
J8C 2E8 (819) 326-3551</p> |
| <p>9.2 Directeur général
Hôpital de Mont-Joli Inc. (P)
800, du Sanatorium
Mont-Joli (Québec)
G5H 3L6 (418) 775-7261</p> | <p>9.9 Directeur des ressources
financières
Le centre Hospitalier de
l'Université Laval (G)
2705, boulevard Laurier
Sainte-Foy (Québec)
G1V 4G2 (418) 656-8235</p> |
| <p>9.3 Directeur général
Hôpital Louis-H Lafontaine (P)
7401, rue Hochelaga
Montréal (Québec)
H1N 3M5 (514) 253-8200</p> | <p>10.0 Directeur général
Hôpital Régional de la
Mauricie (G)
59, 118^e rue
Shawinigan-Sud (Québec)
G9P 4E7 (819) 537-9321</p> |
| <p>9.4 Directeur général
Hôpital Notre-Dame de
 Lourdes (LT)
1870, boulevard Pie IX
Montréal (Québec)
H1V 2C6 (514) 527-4595</p> | <p>10.1 Directeur général
Hôpital d'Youville (LT)
1036 sud, rue Belvedere
Sherbrooke (Québec)
J1H 4C4 (819) 569-9041</p> |
| <p>9.5 Conseiller en procédés
administratifs
Hôpital Saint-Jeanne d'Arc (G)
3570, rue Saint-Urbain
Montréal (Québec)
H2X 2N8 (514) 842-6141</p> | <p>10.2 Directeur général adjoint
Hôpital St-Joseph de
Trois-Rivières (G)
731, rue Sainte-Julie
Trois-Rivières (Québec)
G8Z 3R9 (819) 379-4130</p> |
| <p>9.6 Adjointe au directeur général
Hôpital Saint-François
d'Assise (G)
10, de L'Espinay
Québec (Québec)
G1R 2M6 (418) 525-4421</p> | |

G = General; LT = Long Term; MR = Mental Retardation Facility;
P = Psychiatric.

- 10.3 Directeur général adjoint
Centre Hospitalier de
Verdun (G)
4000, boulevard Lasalle
Verdun (Québec)
H4G 2A3 (514) 761-3551
- 10.4 Directeur général
Centre Hospitalier des
Bois-Francis (LT)
61, avenue de l'Ermitage
Victoriaville (Québec)
G6P 6X4 (819) 758-7511
- 11.0 Assistant Administrator
Penticton Regional Hospital (G)
550 Carmi Avenue
Penticton, B.C.
V2A 3G6 (604) 492-4000

G = General; LT = Long Term; MR = Mental Retardation Facility;
P = Psychiatric.

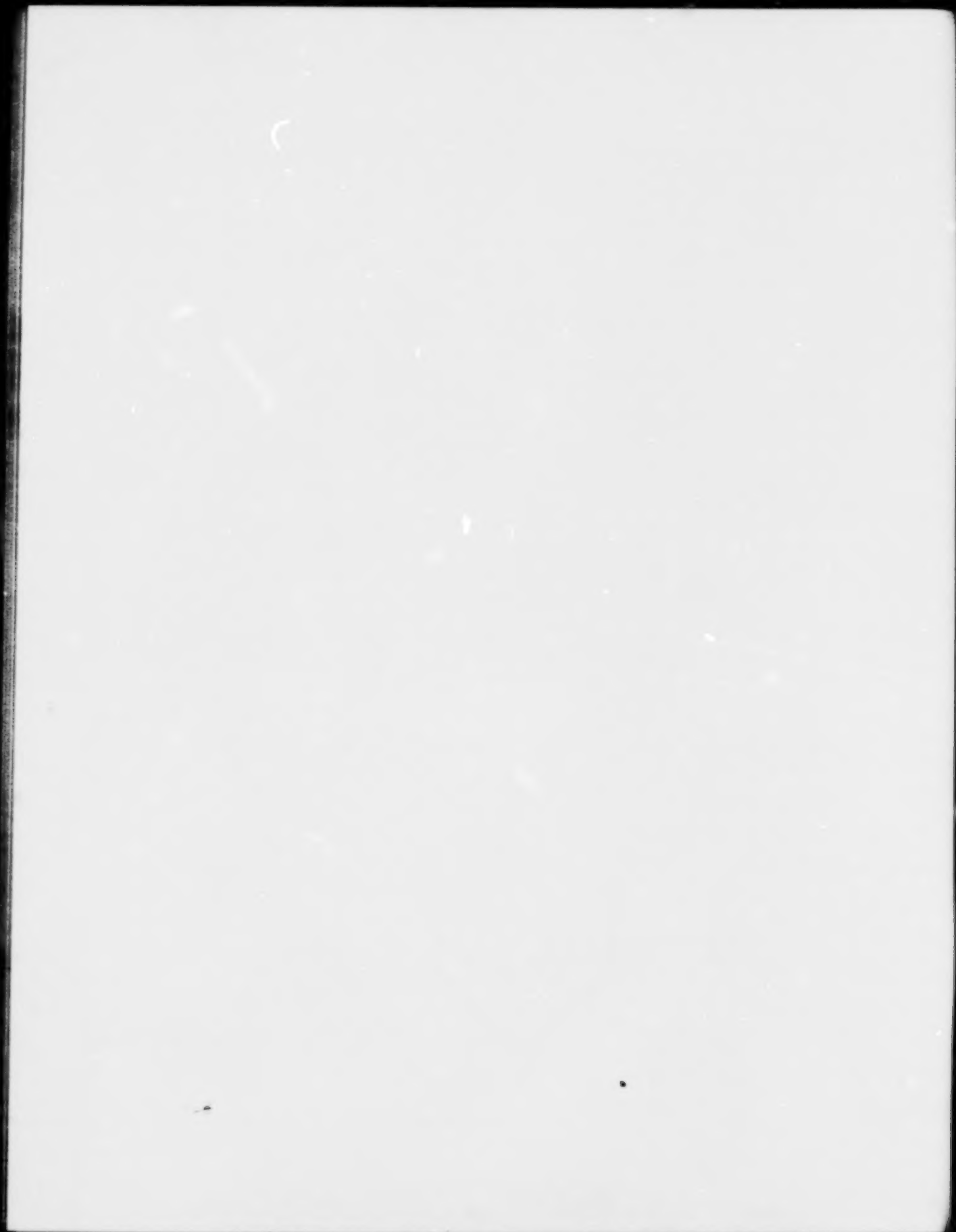
APPENDIX II

LIST OF HOSPITAL ROLES OR EMPLOYEE GROUPS REPORTED AS UNIONIZED BY UNION REPRESENTATIVES

- | | | | |
|----------|---|----------|--|
| A | Adjunctive Therapist
Administrative Staff
Aids
Ambulance
Ambulance Attendants
Ambulance Drivers
APTMQ
Assistant Unit Supervisors
Audio-Speech Therapists
Auxiliary Aids
Auxiliary Nurses
Auxiliary Service Workers
Auxiliary Services | D | Day Care
Day Care Workers
Dental Hygienists
Department Heads
Detoxification
Dietary
Dietary Technicians
Dietetic Technicians Association
of Quebec
Dieticians |
| B | Barber Group
Beautician Group
"B" Technicians | E | Educators
Engineers
E.K.G. Technicians
Electrician Group |
| C | Cafeteria
Cardiopulmonary
Carpenter Group
Central Supply Department
Certified Nursing Assistants
Child Care Workers
Cleaners
Clerical
Clerical Services
Clerical Staff Group
CNA Technicians
Community Mental Health Workers
Computer Operators
Cooks
C.P.D.
C.S.R.
C.U.P.E.
Cytologists
Cytology Technicians | F | Firefighters
Food Services |
| | | G | Gardener Group
General Duty Nurse
General Employees
General Services
General Workers
Graduate Nurses
Guidance Counsellors |
| | | H | Head Nurses
Health
Health Record Librarians
Housekeeping
Housekeeping Auxiliary Staff
Human Behaviour Specialists |
| | | I | Inhalation Therapists
Inhalation Therapy
Inhalotherapists
Inhalotherapy Technician
Institutional Care Workers |
| | | K | Kitchen
Kitchen and Dietary Group
Kitchen Staff |

- L** Laboratory
 Laboratory Assistants
 Laboratory Group
 Laboratory and Public Health
 Laboratory Technicians
 Laboratory Technologist
 Laundry
 Laundry Staff
 Leisure Technicians
 Licenced Nurses
- M** Machine Mechanics
 (Heating Equipment)
 Machinist Welder Group
 Maintenance
 Maintenance Dispatch
 Maintenance Engineering
 Maintenance Workers
 Mason Plaster Group
 Medical Archivists and EEG
 Technicians
 Medical Imaging
 Medical Laboratories
 Medical Laboratory
 Medical Laboratory Technicians
 Medical Laboratory Technologists
 Medical and Radiology
 Technologists
 Medical Records
 Medical Records Librarian
 Medical Records Technicians
 Medical Technicians
 Medical Technologists
 Medical Technologists Association
 of Quebec
- N** Nuclear Medicine
 Nuclear Medicine Technicians
 Nurses
 Nurse Aids
 Nurses' Aids
 Nursing
 Nursing Aids
 Nursing Assistants
 Nursing Attendants
 Nursing Instructors
 Nursing Orderlies
 Nursing Support
 Nursing Support Group
 Nursing Staff
- O** Occupational Therapists
 Occupational Therapy
 Occupational Therapy Group
 Office and Clerical
 Office Clerks
 Office Employees
 Office Staff
 Office Workers
 O.N.A.
 O.N.A. Registered Nurse
 Orderlies
 Orderly
 O.R. Porters
 O.R. Technicians
 Orthopedica
 Orthotists
- P** Painter Group
 Paramedical
 Paramedical Employees
 Paramedical and Nursing Care
 Workers
 Paramedical Nurses (non licenced)
 Paramedical Professional Staff
 Paramedical Technical Staff
 Paramedical Workers
 Paramedics
 Personal Service Workers
 Pharmacists
 Pharmacy
 Pharmacy Assistants
 Pharmacy Technicians
 Physical Educators
 Physical Therapy Technicians
 Physicists
 Physiotherapists
 Physiotherapists Association of
 Quebec
 Plumber Group
 Porters
 Power Engineers
 Power House
 Power Plant and Maintenance
 Building Group
 Practical Orderly
 Professional
 Professional Workers
 Program Consultants
 Psychiatric Nurses (Registered)
 Psycho-Educators
 Psychologists
 Psychologists: Human Relations
 Agents

R	Radiology Radiological Technicians Radiology Technicians Radiology Technicians Association of Quebec Radiotherapy Technicians Recreation Technicians Recreation Therapists Recreational Therapy Group Registered Nurses (General) Registered Nursing Assistants Registered Practical Nurses Rehabilitation Rehabilitation Technicians Respiratory Respiratory: EEG, ECG Respiratory Technicians	T	Teachers Teachers/Monitors Technicians Technicians in Radiology Technologists Therapists Therapists Group Trade People (Helpers) Trades Tradesmen Transport and Ground Maintenance Transportation Group
S	Sales and Stores Group Scientific and Professional Seamstress Group Secretarial Secretaries Security Service Personnel Group Sheet Metal Worker Group Social Science Social Services Social Workers Sonographers S.P.D. Speech Therapists S.P.T.R.M.Q. Staff Nurses Stationary Engineers Stores Supervisors Supplies Processing Support Staff Switchboard	U	Upholstery Group Utility Workers
		W	Ward Secretaries Warehouse Watchmen
		X	X-Ray X-Ray Technicians X-Ray Technologists



APPENDIX III

DEFINITIONS OF STATISTICAL SYMBOLS APPEARING ON TABLES

1. CHI SQUARE

Chi square statistic (x^2) is used to test whether a relationship between two variables is significant. The greater the magnitude of x^2 , the greater the likelihood that the relationship between two variables is real, rather than reflecting sampling fluctuations. The significance of the magnitude of x^2 is judged by the degrees of freedom (d.f.) associated with it in relation to the probability level (P). The degrees of freedom are dependent on the number of categories of the variables being cross-classified. A significant value of x^2 is the one in which, with given degrees of freedom, the probability level (P) of error is less than 5% (P = 5%).

2. CRAMER'S V OR GAMMA

Either Cramer's V or Gamma will appear at the bottom right of each cross-tabulation table. These statistics explain the strength of the relationship between the two cross-classified variables.

- a. Cramer's V is used to measure (summarize) the extent to which two nominal variables are related. This value ranges from zero to 1, with zero reflecting no relationship and 1 reflecting perfect association.
- b. Gamma is used to measure (summarize) the extent to which two ordinal variables are related. Its value ranges from -1 to +1, with zero reflecting no association and the sign reflecting direction. Its value is interpreted as a percentage of the extent to which the two variables are related.

3. THE LETTER "N" APPEARING BELOW EACH COLUMN DENOTES THE NUMBER OF RESPONSES FOR THAT CATEGORY



BIBLIOGRAPHY

- Babbrie, E.A. The Practice of Social Research. Belmont, Wadsworth Publishing Co. 1979.
- Brunet, L. "Quality of Working Life in Hospitals". QWL The Canadian Scene, Vol. 4, No. 1, p. 12-16. 1981.
- Canada. Labour Canada. Adapting to a Changing World: A Reader on Quality of Working Life. Ottawa. 1981.
- Canada. Labour Canada. "What is Quality of Working Life" (experted from Ted Mills, "The Name that Isn't There"). Ottawa. 1981.
- Emery, F.E. Systems Thinking. Baltimore, Penguin Books Ltd. 1971.
- Garrett, R.D. Hospitals - a Systems Approach. Philadelphia, Auerbach Publishers Inc. 1973.
- Gosselin, R. "Decentralization/Regionalization in Health Care: The Quebec Experience". Health Care Management Review. Fall, 1983.
- Hosmer, L.T. Strategic Management. Englewoods Cliffs, Prentice-Hall Inc. 1982.
- Johnston, C.P., M. Alexander and J. Robin. The Idea and Its Application. Quality of Working Life Series. Ottawa, Labour Canada. 1978.
- Kahn, J. "Quality of Working Life in Hospitals: Some Implications for Dietetics Departments". Paper presented at the Annual Conference of the Canadian Dietetics Association, Toronto. June 24, 1982.
- Kolodny, H.F., C.P. Johnston and W. Jeffrey. Job design and Sociotechnical Systems. Quality of Working Life Series. Ottawa, Labour Canada. 1979.
- Mintzberg, H. The Structuring of Organizations. Englewood Cliffs, Prentice-Hall Inc. 1979.
- Ondrack, D.A. and M.G. Evans. Evaluation and Measurements. Quality of Working Life Series. Ottawa, Labour Canada. 1981.
- Robin, J. Concepts and Programs for Change. Quality of Working Life Series. Ottawa, Labour Canada. 1981.
- Shortell, S.M. "Theory Z: Implications and Relevance for Health Care Management". Health Care Management Review, Vol. 7, No. 4, p.7-21. Fall 1982.
- Soderstrom, L. The Canadian Health System. London, Croom Helm Ltd. 1978.

Steers, R.M. Introduction to Organizational Behaviour. Santa Monica, Goodyear Publishing Co. Inc. 1981.

Westley, W.A. and W.M. Westley. "Hospital Organization and the Quality of Working Life". Unpublished paper.

Westley, W.A. The Role of the Supervisor. Quality of Working Life Series. Ottawa, Labour Canada. 1981.

